Private Matters for the Public Good: The Dispensary Movement in Eighteenth-Century England

by

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Class of 2011

A thesis submitted to the
faculty of Wesleyan University
in partial fulfillment of the requirements for the
Degree of Bachelor of Arts
with Departmental Honors in the Science in Society Program

Middletown, Connecticut

April, 2011
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Acknowledgements

To my thesis advisor, Professor Jennifer Tucker, for her thoughtful comments and encouragement.

To my writing tutor, Anna Szapiro, for her assistance developing my thoughts and careful scrutiny of my writing.

To my friends and family members who have read chapters or listened to my ideas, providing me with feedback that I could not have done without.
Introduction

Theorizing health equity is a difficult task given that health is a collective concept composed of various dimensions of the life of a human being. Philosopher Amartya Sen defines health as a “subset of a person’s capability” to participate in his/her milieu.\(^1\) In this conception, the fair distribution of health requires more than equal access to health care. Health equity demands that individuals have the freedom to choose to make decisions that promote their health. Thus, any theory of social justice that is concerned with the fair organization of human capacities ought to value health equity.\(^2\)

Public health ethics, a nascent subdiscipline of bioethics, endorses a social justice framework. In taking this stance, it addresses the pathogenic structures that plague the most “disadvantaged” members of a community as morally significant.\(^3\) Public health practice, within this ethical stance, must engage in “the task of identifying and ameliorating patterns of systematic disadvantage that undermine the well-being of people whose prospects for good health are so limited that their life choices are not even remotely like those of others.”\(^4\) Taking this moral perspective involves asking several questions: What populations suffer from the most severe

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\(^2\) Ibid.


inequalities? What inequalities are most urgent to address? What conceptual method can be used to normatively assess the moral priority of certain inequalities over others?⁵

Asking these questions has relevance for the recent call to reframe the writing of the social history of medicine.⁶ Indeed, this type of medical history “has been politically and morally entrenched in ‘the past.’”⁷ Writing a social history of medicine often entailed a politically left-leaning dedication to social change, placing an emphasis on understanding the nature of inequalities in health care. Many social historians of medicine celebrated the welfare state “as the bearer of this medical humanism,” distinguishing it from privatized, commercial medicine.⁸ However, in today’s world, many privately funded actors and agencies have taken on the project of health promotion and disease prevention in the name of health equity. These philanthropic endeavors comprise a diverse patchwork of assistance, coming from organizations ranging from pharmaceutical companies and media groups to the Bill and Melinda Gates Foundation, faith-based charities, and human rights groups. Especially in the case of ensuring global health, public funding mechanisms often engage in public-private partnerships.⁹ Most of these efforts explicitly focus on

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⁷ @455 Cooter, "After Death/after-'Life': The Social History of Medicine in Post-Postmodernity," 455.
⁸ Ibid.
⁹ The President’s Emergency Plan for AIDS Relief (PEPFAR) is one example. 2009 Annual Report to Congress, "Celebrating Life: The U.S. President's Emergency Plan for Aids Relief," ed. United States
contributing to the welfare of the community. As the current understanding of public health and medicine continue to undergo dramatic transformations, the social history of medicine must make a theoretical shift in its framing of the politics of medicine. Dissecting the concept of medical humanitarianism will afford new insights into our moral responsibility to promote the public’s health. My study of medical charity, which I will explain shortly, will examine whether any formulation of humanitarianism is compatible with social justice and public health.

Studying medical charity offers an opportunity to examine the nature of humanitarian assistance. Medical anthropologist Paul Farmer has often criticized this style of delivery given its implicit acceptance of inequality and its blindness to the confluence of cultural, economic and political factors that produce “victims of structural violence.” Medical charities generally provide the sick poor with necessary medical care in order to address health disparities. This medical relief fulfills one immediate need for those who receive the care, but does not serve to prevent these patients or others from demanding care again in the future. Indeed, discussions of “personal responsibility” and “compassion” for fellow human beings usually obfuscate any “historically deep” analyses capable of identifying pathogenic components built into the socioeconomic structure.

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11 @153Paul Farmer, Pathologies of Power (Berkeley: University of California Press, 2005), 153.
12 @154,158Ibid.
Medical charity, despite such criticisms, has itself continued in a long
historical tradition.\textsuperscript{13} This style of medical relief bears on the broader moral
sensibilities of the culture in which they operate. Historian Charles Rosenberg
explains how these “ethical assumptions imply priorities and constrain choice;
meaning and morality are thus necessarily and inextricably embedded in every aspect
of medical practice: private and public, individual and collective.”\textsuperscript{14} Rosenberg’s
assessment of medical practice as a moral system raises the question of how the
humanitarian rationality frames its social obligation to promote health. As mentioned
earlier, historians often understand the humane motivation of medicine as distinct
from capitalism.\textsuperscript{15} The welfare state stands as the ideal humanitarian form, endorsing
the social rights of citizens.\textsuperscript{16} Studying the perceived moral obligation of charity will
complicate this narrative, demonstrating how the public responsibility for health can
take on different forms.

\textsuperscript{13} Colin Jones, \textit{Charity and Bienfaisance: The Treatment of the Poor in the Montpellier Region} (New
York: Cambridge University Press, 1982); Elizabeth Fee, "Public Health and the State: The United
1994); Christopher Hamlin, "State Medicine in Great Britain," in \textit{The History of Public Health and
\textsuperscript{14} Charles Rosenberg, "Meanings, Policies, and Medicine: On the Bioethical Enterprise and History,"
\textit{Daedalus} 128, no. 4 (1999).
\textsuperscript{15} For example, when historian Charles Rosenberg examined the activities of the voluntary
Pennsylvania Hospital established in 1750 in the United States, he focused on the perceived charitable
duty of the physicians. He noted that doctors were expected to provide the poor with medical
assistance free of charge, and were not morally evaluated on the basis of their behavior in the
economy; in fact, to market one’s services or discoveries was to be labeled a quack. These medical
professionals, Rosenberg explains, acted out of a “socially constructed sense of stewardship, of
categorical moral obligation” to treat the deserving poor (1999, 31).
\textsuperscript{16} T. H. Marshall is often credited for establishing the classical understanding of social, or socialist,
rights. T. H. Marshall, \textit{Class, Citizenship and Social Development} (Chicago: The University of
My study of a popular model of medical charity in eighteenth-century England, the dispensary, will explore the humanitarian rationality at play during this time. Dispensaries were instituted in order to provide free, outpatient medical relief to the laboring poor either at the building itself or in their homes.\(^\text{17}\) From 1770-1800, thirteen dispensaries were founded in London. The relatively quick development of this institution indicated its acceptance within the community.\(^\text{18}\) John Coakley Lettsom, a Quaker, philanthropist and physician, developed the plan for the General Dispensary in 1770, which served as a model for the other dispensaries that followed.\(^\text{19}\) As Lettsom was a prolific pamphleteer and instrumental in the history of the dispensary, I will focus on his writings, while also considering the plans written for many of the other dispensaries established in London.

While all of the dispensaries varied in their particularities, they shared several characteristics: 1) voluntary subscribers, known as governors, funded the operations and designed the rules, 2) governors filled out a letter of recommendation to enable poor patients to receive care, 3) physicians treated these patients either in the dispensary building or in their homes, and 4) physicians, apothecaries (and sometimes surgeons) offered outpatient medical relief, which mainly included self-help advice or


medicine.\textsuperscript{20} These institutional features bear on the moral criteria that both the
benevolent and objects of charity were materially involved in upholding. The rich in
providing medical care and the poor in seeking assistance engaged in a social duty
promote the economic vitality of the nation.

In my first chapter, I will explain the general features of the dispensary in
further detail, as there are few in depth histories written on this topic.\textsuperscript{21} In particular, I
will emphasize the importance of the letter of recommendation and the provision of
domestic care. These two features reflect how the dispensary reinforced a mutual
obligation between the rich and poor, basing the moral duties of the rich and poor
upon the economy of the family. Framing disease as a debilitating force that left the
family unable to work, the medical treatment of the dispensary helped reestablish the
family as a self-sustaining unit of the population.

In my second chapter, I will explore the moral responsibility of the
benefactors in order to understand what motivated their endeavor to dispense medical
relief to the poor. I will more closely examine the life and writings of the Quaker
John Coakley Lettsom, demonstrating how the logic of the capitalist market cannot be
separated from the humanitarian perception of the distress of the poor. Lettsom
valued a social structure in which the poor had the ability to obtain the necessities of

\textsuperscript{20} Loudon, "The Origins and Growth of the Dispensary Movement in England."; Lettsom, "Of the
Improvement of Medicine in London on the Basis of Public Good."

\textsuperscript{21} Loudon, "The Origins and Growth of the Dispensary Movement in England."; Bronwyn Croxson,
"The Public and Private Faces of Eighteenth-Century London Dispensary Charity," \textit{Medical History}
41(1997); Robert Kilpatrick, "'Living in the Light': Dispensaries, Philanthropy and Medical Reform in
the Late-Eighteenth Century London," in \textit{The Medical Enlightenment of the Eighteenth Century}, ed.
life. With this view, he felt morally obligated to assist the poor when they fell into a state of distress that left them unable to work. Because both disease and poverty could produce the problematic condition of distress, Lettsom did not distinguish between the two states of being.

In my third chapter, I will argue that the dispensary demonstrated a humanitarian form of public health practice. The concern to treat disease in the individual served as a preventative function for the public’s welfare: it protected the commercial state from having to care for an ever-growing dependent class. Ensuring the economic independence of the poor involved making changes to the economic and social environment in which they lived by dispensing self-help advice and emergency relief. However, these improvements did not recognize the structural inequalities producing the temporary poverty and disease, which they sought to repair in the name of the public good.

I will use the humanitarian rationality as an analytical tool to demonstrate how the social obligation to provide health to disadvantaged populations is historically contingent. The plan of the London Dispensary wrote, “It will, doubtless, afford peculiar Satisfaction to every humane Disposition to reflect upon the generous and benevolent Spirit, which appears in different Forms, in different Parts of this great Metropolis.”22 My concern will be to uncover how this “humane disposition” understood the problem of disease given the rise of industrial capitalism. The

22 “A Plan of the London Dispensary, Primose-Street, Bishopsgate-without, for Administering Advice and Medicines to the Poor: At the Dispensary or Their Own Habitations Instituted in 1777,” (1783).
changing moral sentiment that accompanied the capitalist system was part of, what philosopher Michel Foucault terms, a “bio-history.” As biological life and political techniques interacted with one another to produce the public’s welfare, the humane responsibility to ensure the health of the laboring poor also developed.

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Chapter 1: Mutual Obligation

The Institute of Medicine in 2003 described the practice of public health as “what we as a society can do collectively to ensure the conditions in which people can be healthy.”\textsuperscript{24} In this statement, the problem of health falls within the sphere of responsibility of a broad range of actors, such as individuals, charitable organizations, or state and federal initiatives. The notion that both public and private initiatives should work to ensure the people’s health was not always emphasized in previous histories of public health. For example, the influential historian of public health George Rosen asserts that “[t]he protection and promotion of the health and welfare of its citizens is considered to be one of the most important functions of the modern state.”\textsuperscript{25} In Rosen’s view, scientific and medical progress led to the development of a rational government that effectively dealt with the problem of population health.\textsuperscript{26} This conclusion contains an ethical dimension: once scientific and medical knowledge had uncovered methods to improve health, then the government was obligated to make them available to the public.\textsuperscript{27} Such a history fails to acknowledge how this obligation came to be accepted. Contributing to a genealogy of public health ethics, I will use the dispensary model to demonstrate how actors other than the state held themselves responsible for promoting the public’s health.

\textsuperscript{24} Institute of Medicine, \textit{The Future of the Public’s Health in the 21st Century} (Washington: The National Academies Press, 2002), 20.
Eighteenth-century England provides an interesting opportunity to examine the context of responsibility, as the strong centralized government did not take charge of the initiatives to promote the public’s health. Rather, local initiatives of both private and public nature focused on ensuring the health of particularized populations: namely, the economically disadvantaged.\(^{28}\) Medical charity was part of a specific relationship between the affluent and the poor, rendering the provision of free medical care a moral duty. The moral dimension of beneficence—whether moral principles “require” or “justify” charitable responses—underlies this discussion.\(^{29}\)

Spheres of personal responsibility do not constitute the ethical domain of public health. Rather, historical, political and cultural circumstances structure the position of certain actors in relation to others and determine how their responsibility is identified and understood. Material practices hold actors morally accountable in a public manner and determine their “specific statuses,” which incorporate the responsibilities they ought to fulfill.\(^{30}\) Responsibility becomes a diffuse phenomenon shared among agents in a social space. Institutions involved in ensuring the health of the public need not be governmental, in the traditional sense, in order to fulfill a social duty.

The voluntary actions of benevolent individuals to provide medical relief to the poor fell within a definition of government that extends beyond the juridical realm. I will use the term “government” to incorporate any institutional practice that

\(^{28}\) Hamlin, “State Medicine in Great Britain.”

\(^{29}\) Beauchamp, \textit{Philosophical Ethics: An Introduction to Moral Philosophy}, 212.

guides “categories of social agent[s]” to behave in distinct ways.\textsuperscript{31} As philosopher Michel Foucault describes, “the art of government” involves “employing tactics” in order “to arrange things in such a way that, through a certain number of means, such and such ends may be achieved.”\textsuperscript{32} Engaging in a sub-type of biopower, what Foucault terms “noso-politics,” dispensaries treated individual sick bodies in order to enable families to remain economically self-sustaining units in the poor population.\textsuperscript{33} As I will discuss shortly, the dispensary model was seen to reinforce the mutual obligations between the rich and poor in order to promote the nation’s welfare.

\textbf{The Humanitarian Domain}

Medical charity did not arise in pre-industrial times, when the state had limited power and wealth was unequally distributed into the hands of a few. Medicine, charity and the state were complexly related; for this reason, it is not historically adept to delineate between what constituted the public and private actions to promote the health of the public.\textsuperscript{34} In England, the Elizabethan Poor Laws had been established in 1601 to take “public responsibility for the Poor.”\textsuperscript{35} The central government granted the poor (categorized as individuals who resided in a building

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valued less than ten pounds per year) with the right to relief for a broad variety of needs, including money, housing, and food. A specific amount of funds were allocated to a number of local parishes, which were responsible for deciding who was eligible for assistance and dispensed relief within their region. Administering relief was a difficult task given that the rates of funding never seemed commensurate to what was actually needed to provide relief.\textsuperscript{36} For this reason, during the seventeenth century the parishes did not desire to take the time or resources to provide care for the sick. A system developed in which the parish officers established contracts with private individuals to care for these sick individuals.\textsuperscript{37}

As the inadequacies of the Poor Laws became clearer for medical and other needs, a number of other routes for receiving assistance developed. Historians have identified neighborhood and kinship networks, friendly societies, and voluntary charities among the multitude of alternative relief services composing a “mixed economy of welfare.”\textsuperscript{38} However, Foucault argues that throughout the eighteenth century, crises in health came to be understood as distinct from other “problems of assistance.”\textsuperscript{39} Foucault explains that “this sudden importance” of medicine “originates at the point of intersection of a new, ‘analytical’ economy of assistance with the emergence of a general ‘police’ of health.”\textsuperscript{40}

\textsuperscript{36} Ibid., 2.
\textsuperscript{39} Foucault, "The Politics of Health in Eighteenth Century," 168.
\textsuperscript{40} Ibid., 171.
the health of the poor over other forms of aid was part of a shift in understanding the community’s needs. The move from perceiving health as a private matter of the individual to a public matter that had to be dealt with embodied the conceptual outlook of the eighteenth century.\textsuperscript{41} Two forms of voluntary charity, the dispensary and the hospital, emerged to explicitly provide the poor with a source of medical care.\textsuperscript{42} Understanding the moral justification for these voluntary initiatives will enhance the discussion of the growing concern for the health of the poor.

The case of medical charity provides a lens with which we can understand how the values defining the concept of health are inextricably linked to economic, political and theological concerns.\textsuperscript{43} The provision of medical relief for disadvantaged populations operated within what I will term the “humanitarian domain”: the conceptual stance governing the techniques of charitable assistance, which were materially enacted through their employment by the rich and poor.\textsuperscript{44} While the transition to the widespread use of humanitarian institutions for medical relief has been explained in terms of the “ethos” of the middle class, whose newfound economic prosperity led to a “new attitude of mind towards problems of community

\textsuperscript{41} Ibid., 166-7.
\textsuperscript{42} Rosen, A History of Public Health, 147.
\textsuperscript{43} Ludmilla Jordanova, "Has the Social History of Medicine Come of Age?," The Historical Journal 36, no. 2 (1993): 444.
\textsuperscript{44} Historian Mary Poovey in her (now seminal) work Making A Social Body offers the most promising methodology to understand the material and the discursive dimensions constituting the dynamic power of medicine. She argues that a domain, such as the economic, is an ontological fiction that can be understood through an analysis of the conceptual framework, or “rationality,” guiding its commitments. The “materiality” of these domains is manifested in certain institutions, which through their particular practices bring the reality of the domains in which they operate to bear. Assessing the stance of these institutions, or their set of questions and mode for answering them, renders the rationality of the domain accessible. Mary Poovey, Making a Social Body (Chicago: The University of Chicago Press, 1995), 6.
life,” this cognitive outlook was part of a more general structure of use during the eighteenth century.45

The increased interest in treating disease occurred as the understanding of labor changed. During the period of 1770-1800, when I will be focused, philanthropists identified new methods for facilitating the working power of the poor. Given the recent wars (Seven Years’ War and American Revolution), the growing cost of food (particularly bread) and the fall in jobs, philanthropists took interest in the economic vitality of the nation. Eschewing those methods that produced a dependent laboring class, philanthropists did not offer the poor jobs. Instead, they sought to provide the poor with the smallest amount of assistance needed to promote their economic independence and ability to labor.46

In the following text I will focus on the dispensary, a form of medical charity that quickly became a dominant model from 1770 to 1800, and continued to exist, albeit in different forms and less prominently, until 1850.47 The dispensary model was formed out of a transitional logic in the humanitarian domain, sustaining ethical commitments to both the moral and political economy. I will follow a Foucauldian framework in order to understand how this concrete moral practice embodied a

particular mode of the humanitarian rationality. Thus, I will approach this charitable institution using a “history of thought” that is distinct from “the history of ideas” and the “history of mentalities.”

Through the provision of medical care, dispensaries addressed the problem of subsistence in families of the laboring poor. This form of medical relief had to be applied as soon as illness hit in order to prevent the family from falling into a state of debilitating poverty.

**John Lettsom’s Dispensary Model**

The writings of John Coakley Lettsom, a Quaker physician and philanthropist, exemplify the humanitarian mode of thought. He established the General Dispensary in 1770. His model served as the prototype for sixteen other institutions within the metropolis and twenty-two within the provinces. Lettsom described the purpose of this medical service in the following manner: “The design of this institution is to administer advice and medicines to the poor, not only at the Dispensary but also at their own habitations; which latter circumstance is an advantage peculiar to this

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49 Ibid., 118. Foucault explains problematization: “It is a question of a movement of critical analysis in which one tries to see how the different solutions to a problem have been constructed; but also to see how these different solutions result from a specific form of problematization”

50 The names of the dispensaries established from 1770-1800 follow: The General Dispensary, Aldersgate Street (1770); The Westminster General Dispensary (1774); The Surrey Dispensary (1777); The London, Artillery Ground (1777); Metropolitan Dispensary, Cripplegate (1779); The Finsbury, St. John’s Street (1780); The Public Dispensary, Carey Street (1782); The Eastern Dispensary, Whitechapel (1782); St. Mary-le-Bone General Dispensary (1785); The New Finsbury Dispensary (1786); General Dispensary, Newman Street (1787); City Dispensary, Grocer’s Hall Court (1789); The Western Dispensary, Westminster (1789); Loudon, "The Origins and Growth of the Dispensary Movement in England," 324.
The medical relief distributed to the poor was free and outpatient. Lettsom’s plan for the dispensary incorporated a general strategy for protecting the health of the public that positioned the family as the object of assistance.\textsuperscript{52}

Dispensary physicians often provided medical relief directly in the homes of the poor. Proposals written for the various dispensaries, in particular, emphasized the practice of home visiting to delineate most aspects of the formal role played by the dispensary within the economy of makeshifts.\textsuperscript{53} Indeed, Lettsom claimed that because many poor found themselves too ill to leave their homes for medical care, they would benefit from this distinct option:

And notwithstanding the many excellent charities, already subsisting for relief of the sick, in and about this great metropolis, yet, when it is considered how many poor, from the nature of their circumstances and disorders, are still necessarily confined to their wretched dwellings, and perish through want of proper assistance, the utility of this institution becomes obvious.\textsuperscript{54}

Domestic care provided the poor whose illness restricted them to their bed with an option to survive. Treating patients in the home was seen to have certain advantages over the other forms of voluntary medical charity, namely the hospital. The dispensary was cheaper to administrate and provide services, it treated infectious diseases outside of sterile environments, and, most importantly, it allowed the sick

\textsuperscript{52}Foucault does not explicitly mention Lettsom’s dispensary, but cites the Quaker model as an example of biopolitics. In this essay, he discusses the dispensary model as a form of domestic hospitalization. Foucault, "The Politics of Health in Eighteenth Century," 172.
\textsuperscript{53}The term the “economy of makeshifts,” coined by historian Joanna Innes, is now used in the historiography of welfare, and emphasizes the variety of options that the poor used to make ends meet. King, "Introduction."
\textsuperscript{54}Lettsom, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and 1774," xix-xx.
poor to recover within the comfort of their families. By representing the family as the object of humanitarian assistance, Lettsom (and other proponents of the dispensary) reinforced a novel way of understanding the problem of health that led to the institution’s popularity.\textsuperscript{55}

Curing the family of disease had a general benefit. Lettsom argued that medical relief addressed “the convenience, interests, and general good of the poor.”\textsuperscript{56} Illness presented a hardship for entire families that could be easily removed with immediate attention: “[s]udden distress, in poor families, may arise from sudden illness, and by moderate temporary relief in the season of affliction, subsequent aid is rendered unnecessary.”\textsuperscript{57} However, if families in need did not receive treatment in a timely manner, then the distress would only grow more severe. Lettsom asserted, “from whatever source it may arise, when a person becomes involved in distress, unless that distress, and the cause of it, be early removed, accumulated misery ensues, and the result is usually the workhouse.”\textsuperscript{58} Distress, regardless of whether disease produced it, proved problematic; if left unattended, families could become dependent upon the Poor Laws, which assigned families living in abject poverty to labor for subsistence in the workhouse.

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\textsuperscript{56} Lettsom, "Of the Improvement of Medicine in London on the Basis of Public Good," 10-11.
\textsuperscript{57} Ibid.
\textsuperscript{58} Ibid.
\end{flushleft}
This role of the dispensary actually served to prevent the sick poor from “the degrading necessity” of seeking the assistance of the Poor Law.\(^{59}\) According to Lettsom, “the moment a family is so involved by the miserable policy of the present poor laws, as either to starve or to enter the doors of a poor-house, all pride of independence, resulting from industry, is annihilated; that kind of independence which is the boast of an Englishmen.”\(^{60}\) The independence of the family was directly linked to its ability function as an economically productive unit. In general, the concern was for the male laborers who supported the family.\(^{61}\)

Since prompt medical relief could prevent the family from falling into a state of debilitating dependence, the humanitarian domain connected health to the welfare of the public. The plan of the London Dispensary asserted, “The importance and Utility of the industrious Poor to a civilized and commercial State are indisputable.”\(^{62}\) In order for the poor to be able to contribute to the nation they had to be able to work. The plan of the Kent Dispensary explained of the “honest” poor, “toil they cannot

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59 “Plan of the St. Mary-Le-Bone Dispensary. Wells Street, Oxford Street, Instituted 1795 for Relief of the Parishes of St. Mary-Le-Bone; St. George; St. Anne; St. Pancras; St. Giles; St. George; Paddington; and Places Adjacent: Supported by the Voluntary Contributions of the Nobility, Gentry, and Others,” (1795).

60 @10 John Lettsom, “Hints Respecting the Distresses of the Poor,” (London: Printed for C. Dilly, 1795).

61 The issues of patriarchy will not be discussed in this piece, but contribute to the understanding of a tempered paternalism. The main instance where Lettsom affords women a place is in his discussion of medical relief for domestic servants. Since women were considered part of the affluent families in which they served, the dispensary’s provision of health provides an interesting discussion of the mutual obligations between the rich and poor. However, these aspects do not differ greatly from how they apply to the more general narrative. Lettsom, "Of the Improvement of Medicine in London on the Basis of Public Good," 31.

62 “A Plan of the London Dispensary, Primose-Street, Bishopsgate-without, for Administering Advice and Medicines to the Poor: At the Dispensary or Their Own Habitations Instituted in 1777.”
Thus, the dispensary considered only the poor who were willing to work when well deserving of aid.\textsuperscript{64}

Ensuring the family’s subsistence was considered relevant to the moral sphere of the dispensary.\textsuperscript{65} The poor’s utility meant that their health mattered to the nation’s wellbeing:

when we consider the immense importance of this class of people, their executive powers in manufactures, in commerce, in arts, and in bodily labour, which are great national concerns, we cannot be too cautious of depressing this love of independence, the genuine fruits of which are virtue, industry and public spirit.\textsuperscript{66}

Understanding health as a resource necessary for independence is part of an economic rationality. The laborer was given agency in maintaining his life through his participation in the market. Thus, his “industry” proved to be his most honorable trait.\textsuperscript{67}

The focus on promoting the family’s economic independence demonstrates how the humanitarian rationality mediated between the logic of the “moral economy” and the “political economy.” The phrase “moral economy,” termed by the social historian E.P. Thompson, describes how “a consistent traditional view of social norms

\textsuperscript{63} “An Account of the Kent Dispensary in the Broad-Way, Deptford for Administering Advice and Medicines to the Poor \textit{Gratiss.},” (London: Printed by W. Hales, 1783), 5.


\textsuperscript{66} John Lettsom, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1" (London: Printed by H. Fry, 1797), 100-01.

\textsuperscript{67} Dean, \textit{The Constitution of Poverty: Toward a Genealogy of Liberal Governance}, 107.
and obligations” evaluated functions of the market. In contrast, when “political economy” governed thought, normative judgments were based in the natural functioning of the market. Lettsom intended for the dispensary model to prevent sickness from damaging the productivity of the family, ensuring its contribution to the nation’s economy. Therefore, maintaining the health of the family became an “instrument” in the dispensary’s “art of government.” The domestic environment provided a space in which to evaluate the moral responsibility of the rich and poor independent of the natural laws of the economy. They could thus engage in a system of mutual obligation. Since the family constituted a unit of the public, governing the lives of the poor individuals within this domestic space provided the means to ensure the vitality of the political economy.

Mutual Obligation

The domestic environment constituted the terms of the moral economy. Lettsom demonstrated how the male breadwinner could not support his family given the prices determined by the market. “As the times now are, a single man may live comfortably with the present price of labor; but a man with a wife and four or five

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70 Foucault, "Govermentality," 99.
children cannot be decently supported.” As a solution, Lettsom suggested that if every single man donated a half-penny to his parish then “it might be sufficient to clothe annually every married man, his wife, and their children, or upwards. This would probably prove an effectual method of equalizing labour with the expenses of a family.” Lettsom’s recommendation utilized the life of the family to evaluate how the benevolent ought to behave in relation to the poor.

As a “form of circulation,” the dispensary facilitated the natural obligations of the rich and poor to one another. “This mutual obligation between the rich and the poor, neither of whom could long subsist without the aid of the other, has in all nations formed the most natural and permanent ground of intercourse between the different degrees of people.” Despite what might be expected, this mutual obligation was not based on a universal human nature. The London Dispensary rationalized, “[the poor] are subject in common with the Rest of Mankind to a great variety of Diseases, so they labour under many peculiar to themselves.” The “natural” bond between the rich and poor was understood in terms of the particular needs of the laboring poor family rather than what they had in common with the “rest of mankind.” Thus, the economic rather than human dimension rendered the provision

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72 Lettsom, “Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1”, 116.
73 Ibid., 111.
75 Lettsom, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and 1774," v.
76 “A Plan of the London Dispensary, Primose-Street, Bishopsgate-without, for Administering Advice and Medicines to the Poor: At the Dispensary or Their Own Habitations Instituted in 1777," 3.
and acceptance of such medical aid a moral duty. The dispensary model’s popularity reflects what E.P. Thompson describes as the “fragile paternalism” found during the eighteenth century.\(^{77}\) He succinctly explains the transformation that occurs: “subordination is becoming (although between grossly unequal parties) negotiation.”\(^{78}\) Thus, the dispensary model was designed in a way so that the affluent could (at least ostensibly) address the specific needs of the poor.

Lettsom’s dispensary model appealed to the moral responsibilities of the rich. Lettsom described how voluntary charities demonstrated personal acts of morality: “the numerous hospitals, and other munificent receptacles for our distressed fellow-creatures, are undeniable proofs of the piety, compassion and liberality of the opulent, which no preceding age ever afforded.”\(^{79}\) Historical aims to identify both the “public” and “private” intentions of the dispensary often recognize humanitarian inclinations as only one motivation among many that led to both medical and non-medical participation of the affluent.\(^{80}\) According to historian George Rosen, the middle-class culture of medical charity at this time “was characterized by two dominant facets: an insistence on order, efficiency, and social discipline, and a concern with the conditions of men.”\(^{81}\) However, Rosen does not acknowledge how the humanitarian

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\(^{78}\) Ibid.: 384.
\(^{79}\) Lettsom, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and 1774," vii.
understanding of the economic order actually grounded their “concern” for the poor. This economic rationality was the basis for the system of mutual obligation.

Letters of recommendation supported the natural system of mutual obligations. Operating within one of the main tenets of the Enlightenment—that the functioning of both community and individual (biological) life followed the “principles of natural equilibrium and harmony”82—the letters of recommendation reinforced the active roles of both subscribers to the dispensary and the sick poor. In this equilibrium of assistance, the “governors” of the dispensary were required to fill out letters of recommendation for the admission of each patient who they deemed worthy of receiving care.83 Governors had to yearly pay one guinea in order to recommend one patient for the dispensary’s list at a time. Ten guineas meant an individual became a “governor for life” and could always place two patients on the list at a time.84 This subscription, therefore, determined how many poor could be admitted: the more governors who subscribed, the more patients could be on the list. Lettsom explained that the “subscription is fixed low, with a view to render the Charity more extensive and give the industrious poor an easy opportunity of obtaining recommendations from their benevolent neighbors, on the earliest attack of illness.”85

The poor, then, were required to seek out such governors when they needed medical

83 Lettsom, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ", 16.
84———, "Of the Improvement of Medicine in London on the Basis of Public Good."
85Ibid., 4.
care and to “return thanks that such a governor may be informed of his right to present another object.”

Poor patients were thus given an active role.

Giving the patients a type of responsibility through the letter of recommendation system distinguished Lettsom’s dispensary from those that had previously existed. In 1769, Dr. George Armstrong instituted a dispensary for the treatment of the infant poor, which he argued ought to be recognized as the model institution. Unlike Lettsom’s dispensary, Armstrong’s never garnered much favor from subscribers and relied largely on his own funding. Armstrong stated the distinctive purpose of his dispensary: “This is the only charity, as far as I know, that has ever been instituted solely for the relief of children…of the Industrious Poor.”

He further noted that it served around thirty thousand from the years 1769 to 1781, when he became too ill to continue managing it. However, due to certain design choices, this institution “met so little encouragement” from the “nobility and gentry” throughout its operation.

The lack of financial support may be due to his appeal to the personal generosity of benefactors, rather than his incorporation of a system of mutual

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86 Ibid., 7.
90 Armstrong, "An Address, Humbly Submitted to the Consideration of the Nobility and Gentry, by Doctor Armstrong."
obligation. Armstrong did not require the use of letters of recommendation because he thought it an inappropriate way to treat infants in need of immediate medical care, especially for diseases like hectic fever. Thus, any infant would be admitted, “provided the parents are really indigent, the case dangerous, and requiring speedy relief.” Armstrong placed an emphasis on those receiving aid without involving notions of duty.

In contrast, Lettsom centered his model about a reciprocal system of obligation. The benevolent assisted in the letters of recommendation to revitalize the poor in a manner that endowed them with moral agency. Lettsom argued that the letters of recommendation facilitated a necessary social interaction for this purpose:

In a free country, where the manners of the people are thus softened an humanized, and amongst whom mutual interests must perpetually subsist, spontaneous gratitude will naturally arise in the poor towards their benefactors, to repay by their industry those obligations which their unavoidable sickness incurred; they not only meet their families with pleasure, but they are animated to follow their daily labour with redoubled cheerfulness and vigor.

As a product of living in the same “free country,” Lettsom framed the poor as sharing a degree of sameness in their manners, which enabled them to participate in a system of “mutual interests.” In giving the poor an active moral role that also served to

91 ________. "An Account of the Diseases Most Incident to Children, from the Birth Till the Age of Puberty with a Successful Method of Treating Them. To Which Is Added, an Essay on Nursing with a Particular View to Children Who Are Brought up by Hand," 199.
92 Donzelot discussed the move from “dependence” to “legitimate moral influence” found in the philanthropic endeavors in France, which is consistent with the dispensary in England. Donzelot, The Policing of Families.
93 Lettsom, "Of the Improvement of Medicine in London on the Basis of Public Good," 21.
ensure their future utility as laborers, Lettsom materially altered the purpose of the dispensary from what Armstrong envisioned.

Seeking medical assistance was explicitly designed to encourage the industriousness of the families even when battling illness. Lettsom argued that dispensaries were “particularly serviceable” for those “poor laboring families, when visited with illness, as have not yet the ability to assist themselves, and are yet willing to exert their utmost endeavors for support in sickness as in health.”94 This expectation actually served a selective function. For example, when appealing to its subscribers, the Kent dispensary stated that the poor would only choose to utilize the dispensary in times of real need: “Your liberality is not likely to be misplaced. For who, amongst the poor, will seek medical advice without heeding it, or take preparations but from necessity?”95 Only the poor who actively met such criteria would be worthy of obtaining the letters of recommendation because they showed an interest in enacting their moral duty. As Lettsom writes, “extensive knowledge of the poor has confirmed in me an opinion, that they are less inclinable to complain of injuries, than to acknowledge obligations: private injuries affect individuals, and mankind are more addicted to hearken to the relation of general good, than partial

94 Ibid., 3.
95 An Account of the Kent Dispensary in the Broad-Way, Deptford for Administering Advice and Medicines to the Poor Gratis.,” 7; Armstrong, "An Account of the Diseases Most Incident to Children, from the Birth Till the Age of Puberty with a Successful Method of Treating Them. To Which Is Added, an Essay on Nursing with a Particular View to Children Who Are Brought up by Hand.”
Reaching out for medical care was an obligation of the poor so they could continue to function as part of the community and promote its welfare.

Letters of recommendation, however, did not distinguish Lettsom’s dispensary from all other forms of medical charity. Indeed, the general hospitals also utilized this system, but to different ends. Lettsom described the dispensary as an “auxiliary to the hospital,” indicating that its role would not displace, but support, the charitable medical institutions already in existence. The dispensary provided outpatient services at both a building to “outpatients” and to “home patients” who the physician, or apothecary, visited in their homes in an assigned geographic region. Dispensaries accepted patients suffering from infectious diseases, namely fever, who were denied access to the hospitals. They officially excluded “chirurgical [surgical], venereal and lunatick cases” because these fell within the responsibility of the hospital or other inpatient facilities.

The emphasis on outpatient rather than inpatient services gave the letters of recommendation a somewhat different purpose. Hospitals represent one form of what E.P. Thompson describes as the spectacle of “patrician power.” In this “theatre of the great,” rare acts of humanity supported by the benefactors maintained an “illusion

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97 Lettsom, "Of the Improvement of Medicine in London on the Basis of Public Good," 2.
98 Ibid., 6.
99 However, in most instances patients requiring surgery were not turned away and sent to the hospitals. In fact, Lettsom even remarked on the success of introducing surgeons into the dispensary model. Ibid.
of paternalism.”

Certain lying-in hospitals, for example, required that the women who had babies delivered participate in a “public show of gratitude” and denied them access to future services if they did not attend. The outpatient services of the dispensary demanded a different quality of thanks. Just as it was the duty of patients to seek out help, it was also the benefactor’s duty to find the poor worthy of their assistance. As Lettsom argued, “modest worth steals from the public eye, and frequents the most solitary avenues,” rendering the domestic dimension of care essential.

The practice of home visiting introduced physicians, and any governors reading relevant reports, into the homes of the “body of the laboring poor, who humbly seclude themselves in miserable courts and alleys.” Dispensary doctors and apothecaries practiced a strenuous form of medical relief. Home visiting commanded that physicians frequently check on their patients suffering from acute diseases, like fever. Apothecaries had to visit such patients daily. Going into the poor patients’ homes also put the physician at risk. John Lettsom recommended that there be “extraordinary physicians” to serve in case a dispensary physician became sick or died. The duty of the affluent only existed given the secluded, miserable conditions

103 Lettsom, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and 1774," ix.
104 Ibid., x-ix.
105 ————, "Of the Improvement of Medicine in London on the Basis of Public Good," 32.
in which the poor lived. These conditions were not the product of poor maintenance of the family, but the life choices of the family determined by the political economy.

Providing medical care to the laboring poor proved a necessity because they suffered from a particularly severe effect of disease given their lifestyles. Lettsom described how many diseases struck quickly and “before the settlement of a poor helpless object can be ascertained, death decides the controversy.”106 As the dispensary carried out the “art of government” by regulating the economic independence of the family, medical relief was intended to prevent the deaths of its members. Indeed, Dr. Hawes of the General Dispensary was “certain that public benevolence will prevent premature death of many, will restore health to numbers, and afford the staff of life to thousands.”107 The plan of the Surry Dispensary explained why such medical relief was necessary given the life of the poor:

As the poor constitute an important part of every large community, they justly merit the attention and assistance of the rich; especially in sickness, when they are rendered incapable of supporting themselves and their families. Hard labour, unwholesome food, want of proper clothing, and exposure to the vicissitudes of air and weather, subject them to many disorders unknown to those whose affluence can procure the conveniencies of life.108

When ill, the breadwinner could not labor to afford the necessities of life for his family. The environment structuring their form of life produced disease as a natural consequence. Thus, disease posed a problem that obligated charitable assistance. To

106———, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ", 92.
ensure that “a hardy race of useful members” was “preserved to the community,”
medical relief had to quickly “restore” their “health, so necessary to their
subsistence.” Categorizing the poor as a “Race” indicated that the obligation to
provide them with care was not based on their universal human nature, but on their
capability to work.

Restoring the health to this laboring race did not target the conditions outside
of the family shaping their lifestyle. Indeed, such an acts did not fall within the
dispensary’s art of government. The preventative nature of the dispensary was not to
eradicate the causes that continued to cause disease, but to promote health in the
family. The charitable work of the physicians and benefactors upheld what Lettsom
term the “PRINCIPIIS OBSTA,” meaning to “remove the cause of distress in its
commencement.” As discussed earlier, medical relief was involved in a more
significant prevention method: keeping the family from falling into a state of
debilitating dependency under the aegis of the Poor Laws. It was of moral urgency to
prevent premature deaths within the family in order to promote the welfare of the
community.

The humanitarian domain considered the continual need for assistance to be a
natural component of community life. According to Lettsom, the poor families’
situation did not allow for the continuance of health: “However, whilst health
continues, the resources which daily open to the industrious in a trading country,

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109 Lettsom, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1", 9.
110 Ibid., 117.
afford also temporary subsistence to their families: but a long continuance of health is the lot of few.”¹¹¹ Though the family functioned as vital unit of the population in health, thereby upholding its moral obligation, it could not continually sustain itself.

**The Family Unit**

The practice of home visiting fit the dispensary model’s program because it valued the family as a nourishing moral environment. Lettsom described the practice of home visiting as “a mode of relief which keeps the branches of the family from being separated, and affords an opportunity for the wife to nurse the sick husband or child, or the husband to superintend and protect a sick wife, which naturally tends to ameliorate and augment the tender affections.”¹¹² The benefit of treating disease “under the fostering care of their own relations, by which love and gratitude are mutually excited and family connexions more firmly established,” created a space that selected for the moral poor.¹¹³ Indeed, Lettsom argued, “while domestic happiness is thus cultivated, the morals of so useful and numerous a class are preserved unassailed and untainted.”¹¹⁴ The healthy family preserved industriousness through its participation in the provision of medical care, reinforcing the positive desire to be healthy.¹¹⁵

The economic crises of the eighteenth century raised the price of goods such as food, clothing, and coal to prices that many laboring families could not afford.

¹¹¹Ibid., 3.
¹¹²Ibid., 2.
¹¹³———, "Of the Improvement of Medicine in London on the Basis of Public Good," 5.
¹¹⁴Ibid.
¹¹⁵Foucault describes the family as “a dense, saturated, permanent, continuous physical environment which envelops, maintains and develops the child’s body.” Foucault, “Politics of Health,” 172.
without difficulty. Jobs were equally scarce.\textsuperscript{116} In 1773, Dr. Hawes, of the London Dispensary, wrote in the \textit{Evangelical Magazine} that the plight of the “distressed weavers” is “not brought on by idleness, intemperance, or a dissolute course of life; but human wretchedness absolutely produced by want of employment.”\textsuperscript{117} Lettsom portrayed the poor as capable individuals given their ability to live in such harsh circumstances:

When I consider the distresses of the indigent, I rather admire that the instances of their misconduct should be so rare: when they behold the affluence, ease of their superiors; when, in spite of their utmost industry, they can with difficulty support their families, and when sickness and disappointments supervene; it is not to be wondered at, if some expressions of discontent should break forth amongst them.\textsuperscript{118}

Lettsom does not fault such behavior because he accepts the right for the poor man to engage in the market, working to gain the wages that can sustain his family.

The dispensary regarded the economic independence of the laborer as connected to the life of the family. A man with a family of “middle station” who reflected upon his own struggle to support it with “some hundred pounds a year” could only come to appreciate the working man “who cannot possibly acquire more than forty or fifty pounds a year” through his labor.\textsuperscript{119} Lettsom wrote, “to support a numerous family with all the necessaries of life, by their small earnings, is an


\textsuperscript{117} Hawes, "The Evangelical Magazine," 253.

\textsuperscript{118} Lettsom, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and 1774," ix.

\textsuperscript{119} Ibid., xi.
invincible proof of the economy and industry that generally prevail among them.”\textsuperscript{120}

The charitable duty, however, did not incorporate advocating for changes to reduce the need for these outbreaks. The “ease” of the affluent and the “upmost industry” of the poor maintained the political economy necessary for maintaining the prosperity of the nation.

The mutual obligation of the rich and poor was a duty to maintain the prosperity of the nation by sustaining life. Lettsom argued that the poor were needed in the community because “they supply both the necessary and ornamental articles of life.”\textsuperscript{121} As discussed at the beginning of this chapter, both the rich and poor relied on one another to subsist in society, be it the affluent with their luxuries or the poor with their (bare) necessities of life. Lettsom argued that the poor “have, therefore, just claim to the protection of the rich, whose interests must direct them to encourage the industrious in their employments, to frame laws for the maintenance of their rights, and to succour them in the misfortunes to which they are unavoidably incident.”\textsuperscript{122} The moral duty to treat the sick was theorized in terms of the economic capability of the nation when it was composed of healthy individuals.\textsuperscript{123}

Regulating the domestic environment proved essential to the upholding the mutual obligations of the rich and poor. The charitable duty of the affluent to support the economic independence of the family reflected the logic of the moral economy.

\textsuperscript{120} Ibid.
\textsuperscript{121} ———, "Of the Improvement of Medicine in London on the Basis of Public Good," 18.
\textsuperscript{122} Ibid.
The industriousness of the family determined the fairness of the market. Part of this industriousness included the poor’s own duty to seek care so they could continue to work after they were healthy once again. Providing the family with assistance served only to maintain their laboring position in relation to the affluent, and the preservation of this order would promote the natural vitality of the political economy. The family unit provided the appropriate sphere of morality defining the mutual duties that the rich and poor had to uphold in order to promote life necessary for the public good.
Chapter 2: Lettsom’s Humanitarian Sensibility

According to historian Christopher Hamlin, “[t]he simple inference that illness is a problem whose solution is health is rare” in the history of public health. This observation draws upon the current biomedical definition of health as the absence of disease or normal biological functioning. Hamlin describes how this conceptualization of health enabled some humanitarian figures to recognize the pathogenic nature of certain socioeconomic conditions, particularly poverty. Most significantly, W.P. Alison, a Scottish dispensary physician who butted heads with the sanitarian Edwin Chadwick in the nineteenth century, argued that abject poverty led to a physiological state of “deprivation” that, in turn, caused many cases of disease. The figure W.P. Alison relates to Lettsom because they were both educated in the same medical tradition at the University of Edinburgh and practiced in the same form medical charity. However, unlike W.P. Alison, Lettsom did not assert that poverty produced biological abnormalities. Rather, sickness and poverty together produced the debilitating condition of distress. Lettsom understood his moral responsibility to provide humane medical relief in terms of the logic of the political economy and therefore could not consider poverty a pathological condition.

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125 However, this definition is not value free, as is described in Christopher Boorse’s account. Christopher Boorse, "Health as a Theoretical Concept," *Philosophy of Science* 44, no. 4 (1977); ——, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no. 1 (1975).
The writings and life of John Coakley Lettsom will offer an example of how the moral-economic discourse of the humanitarian domain in the eighteenth century constituted his theory of health. Lettsom’s prolific pamphleteering affords an opportunity to explore how the experiences or intentions of the affluent influenced their charitable conduct.\footnote{Sandra Cavallo, "The Motivation of Benefactors: An Overview of Approaches to the Study of Charity," in \textit{Medicine and Charity before the Welfare State}, ed. Jonathan Barry and Colin Jones (New York: Routledge, 1991).} Taking this perspective is useful for considering how the social reality of the benefactors of the dispensary was connected to the problem of promoting the poor’s health. Indeed, Lettsom’s dispensary model was relational; it reflected how he understood the rich’s relationship to the health of the poor. For this reason, Lettsom’s concept of health was contingent upon his perception of the positive and negative responses the dispensary produced in the lives of the rich and poor.

\textbf{Public and Private Goods}

Lettsom’s biography enriches an understanding of how humanitarian medical relief related to the project of promoting the nation’s wellbeing. Historian Robert Kilpatrick claims that Lettsom’s medical practice cannot be separated from the philanthropic endeavors that “inspired them” because he “was a Quaker first, a physician second, and a philanthropist third.”\footnote{Robert Kilpatrick, "Living in the Light': Dispensaries, Philanthropy and Medical Reform in the Late-Eighteenth Century London," in \textit{The Medical Enlightenment of the Eighteenth Century}, ed. Andrew Cunningham and Roger French (New York: Cambridge University Press, 1990), 259.} In Kilpatrick’s view, the project to promote the public good was consistent with and informed by the Quaker principles he learned from birth. Indeed, Lettsom’s religious association and participation in the
Society of Friends was integral to his understanding of the role of medical charity. However, it did not provide the foundational basis for his moral understanding or design of the dispensary.\textsuperscript{129} The manner in which he understood the duty of the affluent to respond to the needs of the sick poor was based on his understanding of how to ensure the nation’s prosperity.

Lettsom produced numerous writings on the topic of the provision of free medical relief with the intention of bettering the public. He explained, “I hope my endeavors to promote the interests of medicine, which are synonymous [sic] with the public good, will not appear to have been exerted in vain.”\textsuperscript{130} Lettsom regarded helping the disadvantaged when ill as only one way to promote good for the community. Indeed, the General Dispensary was only one of the many societies he established or participated in.\textsuperscript{131} In his \textit{Hints Designed to Promote Beneficence, Temperance and Medical Science}, for example, he included sections offering “hints” for the creation of a Medical Society of London, a society of “useful literature,” a hospital for “sea-bathing the poor of London,” and a “Bee Society.”\textsuperscript{132} Medicine, then, fit within this broader humanitarian project.

Public good was defined in terms of supporting the nation’s prosperity, and this understanding grounded such charitable obligation. Since the dispensary model

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\textsuperscript{129}Ibid., 257. Kilpatrick explains the dispensary model in terms of Lettsom’s “religious and political beliefs.”
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\textsuperscript{130} John Lettsom, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and 1774," (London: Printed for Edward and Charles Dilly, 1774), xvii.
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\textsuperscript{131} Kilpatrick
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\textsuperscript{132} John Lettsom, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 " (London: Printed by H. Fry, 1797), vi.
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accepted “that the wealth of nations springs from the production of labour; surely then,” the “poor industrious labourers have a just claim to, and merit the care and assistance, not only of the affluent, but of all degrees not pinched with want.”\textsuperscript{133} Due to their capacity to labor, the poor constituted a vital component of the nation and warranted assistance. For Lettsom, acts of humanity could be separated from the moral obligation to support the wealth of the nation. He observed, that “if ever there existed a nation more humane and generous than another, it is this, where relief of every kind is dispensed with a liberality which characterizes it as much for its humanity as for its wealth.”\textsuperscript{134} Separating “humanity” from “wealth,” Lettsom identified the nation’s system of production as distinct from humane actions of individuals. For this reason, the “public utility” of the dispensary was also accompanied by a “private good.”\textsuperscript{135}

Lettsom described the humane actions to treat sickness as guided by the personal feeling of sympathy. He wrote, “[i]t is then peculiarly necessary that the hand of pity should be extended to soften the pangs of a sick bed, and to restore health and ease to the poor in affliction.”\textsuperscript{136} His perspective of medicine as an act of compassion was formulated early in his life. Lettsom was born into the Society of Friends in a Quaker home in the West Indies. After his father’s death he moved to

\textsuperscript{133}Plan of the Finsbury Dispensary, St. John's-Square, Clerkenwell for Administering Advice and Medicines to the Poor at the Dispensary, or at Their Own Habitations", (London1794?), 5.
\textsuperscript{134}———, "Hints Respecting the Distresses of the Poor," (London: Printed for C. Dilly, 1795), 6.
\textsuperscript{135}Plan of the Finsbury Dispensary, St. John's-Square, Clerkenwell for Administering Advice and Medicines to the Poor at the Dispensary, or at Their Own Habitations ", 6.
England at the age of six and was raised in the home of Samuel Fothergill. He became an apprentice for Dr. John Fothergill and Lettsom attributed his “medical creation” to Fothergill’s teachings.\(^\text{137}\) According to Lettsom, Fothergill was an admirable physician of the poor and “however unremitting the diligence of the Doctor might have been to others, his humanity was still more conspicuous to them: to be diligent was his interest, to be humane was the spontaneous effusion of his heart: which the patients saw and felt.”\(^\text{138}\) Lettsom portrayed Fothergill’s humanity as a “spontaneous” performance of his benevolence rather than an act of charitable obligation. Such professional and humane conduct inspired Lettsom and other Dissenting physicians involved in the *Medical Society of London* to establish a medal in Fothergill’s name. This medal was awarded to “the author of the best Dissertation” in answer to a yearly question posed by the Society.\(^\text{139}\)

Just as Lettsom characterized Fothergill’s medical practice in terms of his humanity, dispensing free medical relief to the sick poor followed the individual’s concern for his fellow men. However, disease alone did not elicit this compassionate response. Medical relief operated at different points in the “life-cycle” when disease and poverty were inextricably linked.\(^\text{140}\) According to Lettsom, “…when pain and disease are united with poverty, they form a picture of human woe, that must naturally excite the pity, and engage the protection of those, who have been exempted

\(^{137}\)———, "Memoirs of John Fothergill," (London1786), ii-i.ii.

\(^{138}\)Ibid., 11-12.


from such accumulated misery.” The concern for the sick poor did not solely depend on their biological state of being, and the economic condition of poverty heightened the misery of their situation.

This private good was part of the interactional context in which the benefactors of the dispensary ensured the health of the poor. Subscribing to the dispensary would “indulge his own humane feeling” and result in the governor’s satisfaction or happiness. According to Lettsom, this happiness also mattered to the poor. Lettsom argued that the “occasions of making ourselves happy by extending relief to the needy, are numberless; and would seem adapted to diffuse happiness more generally among mankind.” Notably, Lettsom described how charity distributed happiness “among mankind.” The universality of both the benefactors and objects of charity, however, did not transform their moral response to act into the fulfillment of duty.

The formulation of the private good differed from the system of moral obligation examined in chapter one. Unlike their active responsibility to seek out letters of recommendation, the poor only passively received this happiness. Despite drawing the conclusion that “happiness therefore is reciprocal,” Lettsom noted that it “is of all things the most easily purchased, for beneficence is the source of all

141 Lettsom, "Of the Improvement of Medicine in London on the Basis of Public Good," 2.
142 "Plan of the Finsbury Dispensary, St. John's-Square, Clerkenwell for Administering Advice and Medicines to the Poor at the Dispensary, or at Their Own Habitations ", 6.
143 ———, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ", 9.
happiness, and the occasions for exercising it are innumerable.” Purchasing happiness was not a reflection of the benefactor’s material involvement in the lives of the poor. Indeed, their sense of moral responsibility did not emanate from a recognition that they somehow contributed to the poor’s suffering. In fact, charitable activity necessitated the presence of distress. According to Lettsom, “[i]f affluence and independence could universally prevail, the benevolent would not experience the inexpressible pleasure of relieving the distressed; neither could there exist that grateful satisfaction which modest indigence ever feels from well-timed succour.” Distributing happiness to the poor, therefore, required that the poor remain dependent upon charitable assistance.

This notion of sympathy for the distress of the sick, poverty-stricken poor was consistent with Lettsom’s humanitarian perception more generally. Only after Lettsom began his apprenticeship with Dr. Fothergill did he begin to question the nature of slavery. In 1767, he freed all of the slaves on his family’s plantation in the West Indies. This move became linked to the Quaker abolitionist campaigns, which eventually diffused outward into the community and led to the 1771 Somersett Case pronouncing the inherent wrong of slavery in England. The language Lettsom used to describe why he felt compelled to free his slaves emphasizes a perceived reciprocal relationship: “my own happiness became so closely connected with the happiness of my negroes, that I could no longer withhold from them the natural privilege of

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144 Ibid., 102.
145 Ibid., 10.
freedom, which heaven conferred upon me."\textsuperscript{147} This humanitarian perspective also guided the domestic focus of the medical relief of the dispensary. In visiting the homes of the poor, physicians and other affluent individuals became “acquainted with situations and circumstances of misery which cannot be described.”\textsuperscript{148} He argued that these “[o]bjects of poverty have all those feelings alive, that can rightly estimate the assiduity and the sympathy of those to whom they look up for succour.”\textsuperscript{149} Indeed, these objects “should raise in our hearts that kind of compassion and obtain that aid from us, which we should look for, were such afflictions suffered to overtake us.”\textsuperscript{150} These sympathetic responses encouraged benevolent actions that nurtured happiness in the private lives of both rich and poor without involving the dimension of a mutual responsibility.

The distribution of happiness within the humanitarian domain was only concerned with the poor’s reception of this good. The benevolent did not act as agents for the removal of distress from the population because ensuring happiness came from the spontaneous goodness of their hearts. Indeed, Lettsom did not express a need to advocate for changes in the existing socioeconomic structure. In London, Lettsom wrote, “there is no probability that these causes will ever be removed; but, on the other hand, the affluence of some rises in proportion to the necessities of others,

\textsuperscript{147} Lettsom, "Memoirs of John Fothergill," 71.
\textsuperscript{148} Lettsom ———, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ", 90.
\textsuperscript{149} ———, "Memoirs of John Fothergill," 11.
\textsuperscript{150} Ibid., 85.
whose wants silently petition for their assistance.”151 In this instance, Lettsom left the eradication of the causes of suffering up to chance rather than taking a responsibility for them. He focused on who experienced wealth and who did not as the moral criterion.

**Moral Responsibility and the Market**

Lettsom and other proponents of his dispensary model framed moral responsibility in terms of the logic of the market. As the capitalist system of production emerged in England, it helped shape the conceptual outlook of the “humanitarian sensibility.”152 In this conception, charitable institutions served as the material means of strengthening the bond between the prosperous middle-class and the working poor. Lettsom observed that

WHERE there are numbers of wealthy citizens, there must always exist numbers of poor; the elegance and ease of the former depend upon the ingenuity and labor of the latter; and the opulent have abundantly testified their sense of this connexion, by many costly edifices for the reception and relief of the diseased poor.153

Charities emerged as an expression of how the affluent experienced their relationship with the poor. The affluent only lead a life of “elegance and ease” given the “ingenuity and labor” of the poor. Consequently, the “connection” justifying humanitarian actions was based on the capitalist system of production.

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151———, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ", 10.
153 Lettsom, "Of the Improvement of Medicine in London on the Basis of Public Good," 33.
The affluent intimately understood their relationship to the market and thereby influenced their concept of moral responsibility. As a Quaker, Lettsom was quite familiar with the ability to personally experience positive changes in the market. Many Quaker individuals, occupying positions as “merchants, dealers, and skilled artisans,” achieved much economic success throughout the eighteenth-century. Out of the Industrial and Agricultural Revolutions, the Quakers emerged as a more prosperous middle class able to carry out their charitable urges. For example, Dr. Fothergill, Lettsom’s mentor, started from modest beginnings to gain professional success later in life. Graduating from the medical school at the University of Edinburg, he became the first medical student of this background to become a Licentiate of the College of Physicians of London and eventually developed an enormously successful medical practice.

Lettsom’s focus on providing medical relief to the artisan can probably be attributed to his acquaintance with the market experience of Fothergill and other Quakers. Lettsom explained, in a fashion almost identical to the one above, how “the artisan always depending upon the affluent for employment” would achieve “the success” that was “always necessary to the ease and convenience of the affluent.”

The dispensary model thus understood the suffering of the poor as a problem in

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154 Kilpatrick, "Living in the Light": Dispensaries, Philanthropy and Medical Reform in the Late-Eighteenth Century London," 261.
156 Lettsom, "Memoirs of John Fothergill."
157 ———, "Of the Improvement of Medicine in London on the Basis of Public Good," 18.
relation to their connection within the market. For example, the plan of the St. Mary-le-Bone Dispensary described how “The industrious Labourer, Mechanic or Artisan, who has hitherto only been able to make his earnings and his wants keep even pace, without forming a reserve for any accidental Affliction that may befall him, is at length, perhaps, seized with a dangerous malady,” necessitating assistance.\footnote{158} The understanding of the poor’s misery was understood in terms of their inability to save up money for times of emergency. Yet, as will be discussed shortly, the laborers’ difficulty to save did not mark a form of inequality.

Giving the poor the ability to sustain their lives as laborers was part of Lettsom’s project to discourage the poor’s dependency. Historian Kilpatrick argues that the Quaker principle of the “inner light,” in which every individual is entitled to a relationship with God in a state of independence, guided the outpatient model of the dispensary.\footnote{159} However, Lettsom’s aim to encourage independence was also consistent with the logic of political economists. In general, they argued that the nation’s ultimate prosperity and wellbeing would be reached if men were free from their dependent states and able to engage commerce. The morality of such laborers would improve if given the opportunity to participate in the domain of “economic interdependence.”\footnote{160} Similarly, Lettsom embraces the expansion of commerce into

\footnotetext[158]{Plan of the St. Mary-Le-Bone Dispensary. Wells Street, Oxford Street, Instituted 1795 for Relief of the Parishes of St. Mary-Le-Bone; St. George; St. Anne; St. Pancras; St. Giles; St. George; Paddington; and Places Adjacent: Supported by the Voluntary Contributions of the Nobility, Gentry, and Others," (1795), vi.}

\footnotetext[159]{Kilpatrick, "Living in the Light": Dispensaries, Philanthropy and Medical Reform in the Late-Eighteenth Century London," 262-263.}

the lives of both the rich and poor: “[i]n a country where many individuals are
enriched by commerce and where all people are possessed of civil liberty, and the
unrestrained exercise of their faculties, the ornamental and necessary arts must
unavoidably flourish.”¹⁶¹ If the laboring poor were able to remain independent agents
within the system of commerce, then the material “arts” could sustain the reciprocal
relationship between the rich and poor.

Valuing the incorporation of the market into the lives of independent laborers,
Lettsom recognized certain economic realities to be of moral urgency. Lettsom
argued, “wherever many persons are employed, labor must be cheap; the earnings,
therefore, of the artisan, will seldom exceed his expenses, and as many of these arts
depend upon circumstances in their nature, multitudes must be liable to suffer a
temporary poverty.”¹⁶² His concern was not with the cheap wages causing the artisan
to barely break even. Instead, he saw the natural circumstances of the artisan’s
lifestyle as problematic. He noted that it was not always possible to obtain the
necessities for subsistence. What struck Lettsom as “laudable [were] the exertions
every where making to a catastrophe dreadful even in idea, of starving in a land of
wealth and luxury.”¹⁶³ These charitable endeavors addressed the commonplace
instances of temporary poverty, ensuring that men did not starve in times of need. The
moral obligation that arose among the affluent in response to the poor’s temporary

¹⁶¹Lettsom, "Of the Improvement of Medicine in London on the Basis of Public Good," 19.
¹⁶²Ibid.
¹⁶³———, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ",
112.
and unfortunate situations was based on the need to fulfill a personal commitment to better the situation of others.

**Humanitarian Prevention**

Addressing the poverty of the family fell within the personal sphere of morality and relied on sympathy. Lettsom described how poverty could be addressed by the private ethic of the individuals:

> To see gentlemen entering the hovel of the poor man, and ladies sympathizing in the chamber of the poor woman, would elevate the dignity of human character; and whilst it cheered poverty, it would tend to promote a virtuous exertion to overcome it by industry.\(^{164}\)

In this statement Lettsom clearly demonstrates that poverty could only be prevented by industry encouraged by the humane sentiment. Encouraging industry within the domestic sphere fits with the discussion of the moral economy in the previous chapter. Thus, the lifestyle of the family guided the charitable response of the dispensary.

Framing disease as one component contributing to the poor’s misery, the humanitarian duty fulfilled a preventative purpose. However, the duty to prevent the sufferings of the poor did not need to target the broader structural arrangements that caused the poor to lose access to the necessities of life in the first place. Leaving the casual relationship between disease and poverty ambiguous, Lettsom treated their composite effects, calling it distress. He was not haunted by the factors producing distress and argued, “from whatever distresses of the poor may originate, present

\(^{164}\) ———, "Hints Respecting the Distresses of the Poor," 12.

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misery requires present aid.” The humane response privileged the poor’s present predicament as unfair rather than the circumstances leading to its presence. Since he perceived of sympathetic action in terms of the market, both poverty and disease were perceived as inevitable in the lives of the poor.

Lettsom’s Quaker identity was integral to his understanding of the appropriate charitable response to poverty and to an implicit acceptance of its prevalence. Indeed, he reflected upon the economic success of the Quakers and noted, “[a] religious society, consisting of about fifty thousand members, for the most part of the middle and lower classes, has existed in this country for upwards of a century, in which abject poverty is the condition of none.” The system of “principiis obsta” or the removal of “the cause of distress in its commencement,” which guided the dispensary model as discussed in chapter one, had a Quaker origin. In the religious society, a person in need applied for assistance and then “two persons [were] appointed to visit him and to administer such aid as the nature of the case may require.” It is clear that participation in charity more generally was seen to follow a similar system of morality. For example, Lettsom urged other affluent individuals to partake in the provision of relief using similar language: “Never be weary, humane citizens, in the godlike work of averting misery from, and administering comfort to, the poor man,

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165 Lettsom, Med in London on Basis Public Good
166 Lettsom, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ", 115.
167 Ibid., 117.
168 Ibid.
his industrious wife, and their helpless children!” To prevent distress through emergency relief fulfilled an individual’s personal morality, an imperative, which in Lettsom’s case had its root in the religious ethic. However, this personal morality was ultimately perceived as part of the benevolent duty to prevent the poor’s distress from negatively affecting the community.

The duty of the benevolent was not to prevent the poor from falling into temporary states of poverty. Humane aid only had to be “timely and properly applied,” unlike the assistance of the parish system, in order to avert misery. The plan of the St. Mary-le-Bone Dispensary described the almost circular relationship between poverty and disease, rendering medical treatment a moral imperative: “Penniless, and without the power of maintaining proper Medical aid, he either falls a sacrifice to the violence of his disorder, or long remains tormented with Pain, and loaded with the complicated Misery of Sickness and Poverty.” Lettsom explained how emergency relief was preventative in nature. Indeed, it stopped the effects of misery and disease from getting worse:

…the first step towards poverty, with only trivial aid applied in the instant, is easily reclaimed, and progressive descent prevented: but as distress encreases [sic], the difficulty of obviating it is augmented; it is, therefore, of the utmost importance to the community to close the wound, on the first application, with the oil and the honey, before it cankers, and becomes incurable.

Treating disease was preventative because it relieved the community from having to deal with a growing number of poverty-stricken, dependent individuals.

169———, “Hints Respecting the Distresses of the Poor,” 7.
170“Plan of the Mary-le-Bone Dispensary,” vi.
171———, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ", 99.
The duty of the benevolent responded to the level of distress from which the poor suffered. Understanding and evaluating this distress came from directly engaging with the lives of the poor, albeit in a fashion that did not afford them a fully conscious voice. The poor could only visibly display their suffering to the benevolent, who could then fully understand the injustice producing what they witnessed.\textsuperscript{172} Lettsom takes this stance in a piece he published in the Gentleman’s Magazine entitled “A Morning Walk in the Metropolis” in 1780.\textsuperscript{173} In this narrative, he is “accosted” by a man whose face “exhibited such a picture of distress and poverty as caught [his] attention.”\textsuperscript{174} The poor man, Foy, was forward with the doctor and his voice was characterized by his dire need; he persuaded Lettsom to ask about his situation. The information Foy provided to Lettsom only discussed how he was forced to return to work in his weak state in order to support his sick family at home. Lettsom evaluated Foy based on his words and image in order to conclude that “[t]his poor object seemed to feel distress too deeply to be an imposter.”\textsuperscript{175} This assessment legitimized his charitable response.

When Lettsom later travelled to Foy’s “miserable habitation” he was met with an entire family in need of assistance. Lettsom alone had the expertise to diagnose the

\textsuperscript{172} Lettsom’s medical approach follows the logic of the Abolitionists who framed slaves as worthy objects due to their “inarticulate” calls of justice. As McGowen remarks, “[s]uffering possessed a ‘truth’ that spoke beyond what the sufferer said about it, spoke through the victim to the one who observed and understood it.” Randall McGowen, "Power and Humanity, or Foucault among the Historians," in \textit{Reassessing Foucault} ed. Colin Jones and Roy Porter (New York: Routledge, 1994).

\textsuperscript{173} Lettsom, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ", 93.

\textsuperscript{174} Ibid.

\textsuperscript{175} Ibid., 95.
conditions under which they suffered. For example, on one bed lay Foy’s half-dressed wife who was “incapable of telling her complaints.” Lettsom diagnosed her with putrid fever given her black lips and gums. Foy’s three children also suffered from fevers that rendered them incapable of any speech that was fully aware of their situation. For example, one of Foy’s daughters cried out for her four-year-old sister to fetch her water. From this display Lettsom concluded, “I now experience how greatly the sight of real misery exceeds the description of it.” The duty of the benevolent was grounded in their conscious ability to dissect what aspect of the poor’s misery demanded a solution.

Lettsom’s commitment to ensuring the public’s good led him to behave in a manner some critics actually deemed incompatible with the Quaker ethic. For example, the physician Thomas Skeete, who desired to be elected as the physician to the New Finsbury Dispensary in 1786, chose to emphasize Lettsom’s religious background when expressing disgust over the significant degree to which he involved himself in the election and his propensity to advertise his charitable commitments. Skeete explained that “[i]t appeared so very inconsistent with the good order and government of the Society of Quakers, that any one of their body should officiously...
intrude into the concerns of others...under the pretences of humanity and charity."

Skeete contrasted Lettsom’s conduct with that of Fothergill’s, “to whom he wishes to be thought a successor, and whose memory was deservedly esteemed.” Skeete pointed to the dimension of Lettsom’s life sometimes taken up by historians: the use of charity to facilitate his own private success. Despite potentially hypocritical behavior, Lettsom’s closeness to the market led him to feel causally implicated in the lives of the poor; for this reason, his humane sensibility can be understood as authentic.

While Lettsom promoted the dispensary as a way to cure the laboring poor and revitalize the workforce, his concern was not just a matter of class, religious or political interest. Rather, the pervasive force of the market that shaped every aspect of life, including health, contributed to a different humanitarian view of society’s problems. Foucault described how many endeavors intended to ensure that the poor enjoyed the resource of health defined their role in terms of poverty:

This analysis has as its practical objective at best to make poverty useful by fixing it to the apparatus of production, at worst to lighten as much as possible the burden it imposes on the rest of society. The problem is to set the ‘able-bodied’ poor to work and transform them into a useful labour force, but it is also to assure the self-financing by the poor themselves of the cost of their sickness and temporary or permanent incapacitation and further to render profitable in the short of long term the educating of orphans and foundlings.

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179 Ibid., 2.
180 Ibid., iv.
181 Roy Porter, "'I Think Ye Both Quacks': The Controversy between Dr. Theodor Myersbach and Dr. John Coakley Lettsom," in Medical Fringe & Medical Orthodoxy 1750-1850, ed. W. F. Bynum and Roy Porter (Wolfeboro: Croom Helm, 1987).
Thus, Foucault captures how poverty was seen in conjunction with health rather than as an etiological agent. A state of health was the individual’s ability to enter into the market as independent agent.

Any moral obligation of the rich or poor was derived from the capitalist system that ensured the nation’s wealth. As seen earlier, together poverty and disease necessitated the charitable response of many affluent individuals in London: “But affecting as the picture of poverty united with disease may appear, it serves to heighten our approbation of the generous and benevolent spirit, which every quarter of this city nobly exhibits.”\(^{184}\) Not all responses to the condition of distress proved acceptable. Lettsom described some aid to be “not only useless, but even injurious to those for whole benefit they are designed.”\(^{185}\) He scorned the practices of some wealthy individuals who provided the poor with oxen or, even worse, ale during generally prosperous seasons. Such relief “neither tends to good morals, nor to preserving industry; but, on the contrary, is destructive of both.”\(^{186}\) Lettsom valued the private ethic as part of carrying out the public duty.

Lettsom did not recognize a causal connection between poverty and disease because he was not concerned with the distribution of health to the poor. Lettsom argued that aid should go to things like coal or clothing for the “channels of real

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\(^{184}\) Lettsom, "Of the Improvement of Medicine in London on the Basis of Public Good," 20.

\(^{185}\) ———, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ", 114.

\(^{186}\) Ibid.
charity” affect “the permanent succour of distress and pining want.” Providing these forms of economic assistance enabled the laboring poor to remain independent laborers and also prevented the community from suffering from an augmenting class of dependents. They desired an ideal structure in which the poor could continually attain subsistence through their labors. According to Lettsom, “NOTHING contributes more effectually to the establishment of good government among the lower and middle ranks of society than the species of equality which enables every man by his industry to procure, at all times, the necessaries of life.” Lettsom endorsed an equality of subsistence, and focused on the outcome in which this was possible.

Intimately bound up with capitalist logic, Lettsom did not privilege health as a moral concern. Health was a fortuitous, but incidental, factor that contributed to a man’s industry. Lettsom did not conclude that disease was a poverty-induced condition because he did not abstract the biological from the moral-economic assumptions of the humanitarian domain.

187 Ibid.
188 ______, "Hints Respecting the Distresses of the Poor," 3.
Chapter 3: Humanitarian Patterns of Public Health

When John Simon, the City of London’s first medical officer in 1843, wrote his history of public health, he described the “New Humanity” of the eighteenth century as working toward a form of social justice.\(^\text{189}\) Simon celebrated how “unaggrieved [sic] persons of humane mind were largely impelled to range themselves on the side of aggrieved classes, and to support their demand for legislative reforms.”\(^\text{190}\) Indeed, during the eighteenth century a number of “backbenchers” introduced legislation to the Parliament that was focused not on particular interests, but on addressing general concerns.\(^\text{191}\) The humanitarian reformers who Simon referenced fell within this tradition. According to Simon, the humanitarian stance endorsed several overlapping principles including “the implied contract of mutual helpfulness, the supreme sanctity of equal justice, the essential coherence of social duties with social rights.”\(^\text{192}\) However, the efforts to introduce laws related to ensure the health of the population cannot be described in terms of social, or socialist rights.\(^\text{193}\) Within the humanitarian domain, the poor were granted health in order to promote the nation’s wealth. From Lettsom’s dispensary model it is apparent that the obligation to promote health was derived from the poor’s ability to work rather than their human nature.

\(^\text{190}\) Ibid., 136.
Health as Economic Resource

The humanitarian domain conceptualized health as a resource, which the poor simultaneously required to participate in the market and deserved given their choice to labor. Lettsom explained “whilst health continues, the resources which daily open to the industrious in a trading country, afford also a temporary subsistence to their families.”\(^\text{194}\) When able to work, the family could then subsist on the necessities of life that the breadwinner purchased, albeit only for a brief period. Lettsom did not regard health as a condition fundamental to the life of the human being. Rather, he regarded health as a fortuitous event required to uphold the poor’s industriousness. In times of need, the poor indirectly purchased their health from the dispensary; their future industry would once again contribute to the economy and lifestyle of the affluent.\(^\text{195}\)

Consequently, the benevolent duty to provide the poor with the “currencies of health”\(^\text{196}\) framed the pathological as the individual’s inability to participate in the capitalist economy. According to Foucault, capitalism “started by socializing, the first object, the body, as a factor of productive force, of labor power”; thus, treating disease and providing the poor with basic goods served as a “collective” or “social”


\(^{195}\) As an interesting point of comparison, Paul Farmer describes commodified medicine as based on the assumption that “health is a desirable outcome to be attained through the purchase of rights and services.” Paul Farmer, Pathologies of Power (Berkeley: University of California Press, 2005).

The humanitarian domain privileged the body as the site of regulation, incorporating certain practices that addressed the social environment of which the biological body was a part. This aim falls within Foucault’s description of the dual layers of biopower. Biopolitics—defined generally as the institutional performances of power used to control life—took on two mutually reinforcing forms. One type focused on maximizing the efficiency of individual “machinic” bodies in order to utilize their ability to labor. The second type focused on the body as a manifestation population trends (mortality rates, morbidity rates, birth rates) in order to control life as species. Lettsom’s dispensary adopted both political techniques in order to ensure that poor maintained a form of life conducive to health.

Within the humanitarian domain, the market did not directly serve as the site of justice. The natural behavior of the economy determined the price for the buyer and seller of such necessities, but when the conditions were unfavorable the charity of individuals enabled the laboring poor to obtain these goods without needing to enter

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200 Foucault, "Right of Death and Power over Life," 262.
201 This trend represents a shift from the sixteenth and seventeenth centuries when the market was “privileged” as a site of distributive justice. ———, The Birth of Biopolitics, 30.
the market. Lettsom described the humane duty as providing the necessities of life in times of difficulty:

The plan of buying food, fuel, and clothes for the poor, whose little pittance does not enable them to go to the best market, is truly laudable and may save thousands from debt, famine and death, till better weather and better times may afford them other means of support.

The “laudable” act of distributing necessary goods did not address the market in terms of the particular needs of the charitable objects. A humane response provided the poor with the means for future economic independence.

The capitalist understanding of the individual’s sphere of influence within the market helped shape the humanitarian conception of moral responsibility. Though Lettsom and other dispensary literature did not employ the term social, this contractual system prepared the conditions for its future use. Working to better oneself, whether by relieving distress or asking for assistance, was seen as integral to the success of the community. Participating in charity was consistent with performing a type of social duty. Such acts were seen to make a difference in the lives of others. For example, Lettsom acknowledged that when the affluent made sacrifices, such as ceasing from eating bread one day a week or eating more potatoes instead, they could influence the market and lower the price of bread for the benefit of the

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203 In the classical conception of social justice, the social dimension is explained as follows: “People are inherently social creatures, dependent on one another for the fulfillment of their needs and potential, and willing to recognize their responsibilities to others as well as claiming their rights for them.” Commission on Social Justice, "What Is Social Justice?," in *The Welfare State Reader*, ed. Christopher Pierson and Francis G. Castles (Malden: Blackwell Publishing Inc., 2000), 62.
204 Marshall, *Class, Citizenship and Social Development.*
poor. He wrote, “[i]f every person will not submit to this trivial sacrifice, or others
deem that a few individual examples are inadequate to any benefit of the community
at large, let such remember that of the smallest atoms masses of the greatest bulk are
composed.” Individuals, Lettsom emphasized, composed the community.

Supporting economic growth had to occur through methods that incorporated
healthy laboring bodies into the phenomenon of capitalist production. The
dispensary’s approach to health promotion addressed those conditions that produced
the distress of the poor. Lettsom described the city as the site in which such misery
occurs; indeed, its public, and seemingly just, exterior is actually the home of silent
suffering:

Great cities are like painted sepulchers, their public avenues, and stately
edifices, seem to preclude the very possibility of distress and poverty: but if
we pass beyond this superficial veil, the scene will be reserved; the pleasing
lights and shades of the picture will be blended with, and lost in the dark
background.

Preventing distress meant repairing the environmental factors that impinged upon the
laborer’s economic independence and ultimately proved dangerous for the public’s
welfare.

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205 John Lettsom, "Hints Respecting the Distresses of the Poor," (London: Printed for C. Dilly, 1795),
23.
206 Foucault, "Right of Death and Power over Life," 263.
207 Lettsom, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and
1774," x-xi.
208 Christopher Hamlin, "State Medicine in Great Britain," in The History of Public Health and the
A Form of Public Health

Many historians point to the methods of disease prevention within the humanitarian domain as evidence of the eighteenth-century public health movement. They emphasize the increased attention paid to sanitation and hygiene measures, indicating how this trend reflected the realization that disease prevalence was connected to unsuitable living conditions. While, indeed, this concern was characteristic of the humanitarian efforts to prevent disease, it does not account for the broader rationality of which it was a part. The humanitarian form of public health endorsed an ethical framework that valued the health of society in terms of economically fit agents. For this reason, the dispensary’s project to address social determinants of health for the laboring poor did not frame disease prevention as its primary object.

Lettsom understood the problem of distress among the laboring poor as a feature of the capitalist system sustaining the nation. Indeed, we saw in chapter two how he explained brief episodes of poverty and sickness as part of the life of the laboring poor. He did not perceive the distressed laboring poor as suffering from some form of injustice. In many ways they were seen as fortunate, rather than victims of society:

During the last three years, I have attended nearly six thousand poor persons, into many of whose habitations I have entered, and been conversant with their sufferings, and their resignation under them; in both of which they have

210 Ibid.
exceeded many of their fellow-creatures, whose lot has cast them in a superior station, and whose contentment under temporary miseries, should ever be sustained by this comparative reflection: ‘What myriads wish to be as blest as I.’

Since he described many of dispensary patients as experiencing “contentment under temporary miseries,” it is apparent that this distress did not indicate economic inequality as the source of social concern. Speaking with the poor through the practice of home visiting, Lettsom considered the consensus to have reached a different conclusion.

The accepted problem with distress proved to be the constricting limits it placed on the utility of the poor. Disease was a central contributor. Lettsom observed that “[s]ometimes, indeed, by successive attacks of illness, they are incapable of procuring the common necessaries of life; they have literally wanted bread, as well as cloaths [sic].” He found entire families “chained by disease” and unable to work to maintain their milieu. The domestic environment, which we saw in chapter one to be central to the economic and moral conduct of the poor, was transformed into a pathogenic area. Leading a life restricted to the bed, “they have thus continued till the payment for their wretched dwellings became due, when this dismal confinement has been changed for the horrible restraint of a prison, loaded with putridity and poison.”

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212 Lettsom, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and 1774," xi.
213 Ibid., xii.
214 Ibid.
domain because it mediated between the economic and biological dimension of the family’s distress.

**Disease and the Environment**

Within the humanitarian domain, the medical perspective recognized the centrality of the environment in disease causation. As many were political and religious Dissenters, these individuals were denied access to the universities of Oxford and Cambridge.\(^{215}\) They often trained in Edinburgh under the physician and theorist William Cullen who emphasized how environmental factors could produce debility, which he considered the “foundation” of a disease like fever.\(^{216}\) Cullen described external factors like “contagion, miasmata, cold, fear” as remote, rather than proximate, causes of disease.\(^{217}\) Cullen’s theory influenced Lettsom’s own understanding of disease, particularly infectious diseases such as fever. As will be discussed shortly, Lettsom’s understanding of the body as part of its environment shaped his notion of disease transmission and the medical relief utilized in the dispensary.

Lettsom’s fever theory incorporated notions of both miasma, noxious air arising from filthy conditions or marshes, and human contagion.\(^{218}\) Lettsom intended for the outpatient services and domestic care of the dispensary model, as mentioned in

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\(^{215}\) W. F. Bynum and Roy Porter, eds., *Medical Fringe and Medical Orthodoxy* (Wolfeboro: Croom Helm, 1987).

\(^{216}\) William Cullen, *Institutions of Medicine. Part I. Physiology. For the use of the students in the University of Edinburgh. By William Cullen, M.D. Professor of the Practice of Physic, &c. &c.* (Edinburgh, 1785), 7.

\(^{217}\) Ibid.

chapter one, to be especially suited to treat fever. One of the reasons, Lettsom argued, was that many poor individuals suffering from infectious disease were “of a tendency improper for reception into one ward, previously crowded with numbers of their diseased fellow-creatures.”

Many plans argued, “Hospitals are also much less salutary than Dispensaries” because their style of humane care harbored the transmission of infections. Lettsom’s dispensary proved more effectual in preserving health given the prevailing understanding of the body in relation to its social environment.

Disease played a normative role within the humanitarian domain because it demonstrated what the body ought to be able to accomplish as part of its surroundings. As discussed earlier, the body of the breadwinner was supposed to be fit to labor and able to prevent the fall into debilitating poverty. Treating the sick body directly implicated their behavior in the market given the concept of sensibility found in the physiology taught at the Edinburgh Medical School. Cullen endorsed a theory in which the nervous system mediated between the body and mind (considered in close connection to the soul). The “sensibility of the nerves” depended upon the “physical state” of the body, and translated their change to the soul.

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220 "Plan of the Finsbury Dispensary, St. John's-Square, Clerkenwell for Administering Advice and Medicines to the Poor at the Dispensary, or at Their Own Habitations ", (London1794?).
223 Ibid.
causes found in the environment led to states of debility. For this reason, the biological changes caused by a disease could impact the social behavior of an individual.

Lettsom endorsed similar views when he discussed the importance of independence for the laboring poor. For example, he criticized the workhouse approach of the Poor Law because of its negative environment. Lettsom asserted that

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\text{[e]very passion that gives energy to soul and body seems buried in the common wreck of his independence; his offspring imbibe the same inertia, and a mean, beggarly, squalid race, is generated, doomed to become a burthen to themselves, and to the community, as long as the same policy is pursued.}\]

Lettsom emphasized how external stimuli affect both the vitality of both the body and soul. The importance he placed on the conditions in which the poor lived had further significance for understanding the connection between physical states and behavior. The workhouse did not provide the appropriate environment to encourage a self-motivated industriousness. Indeed, the offspring embodied a sensibility that led to the “inertia” he scorned.

As another cause of debilitating dependence, disease invited Lettsom’s concern for the environment in which the poor were living. Fever demanded a

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224 According to Cullen, “The remote causes are certain sedative powers applied to the nervous system, which, diminishing the energy of the brain, thereby produce a debility in the whole of the functions…and particular in the actions of the extreme vessels…” Cullen, Practice of Physic, 39.

225 The workhouse was intended to reform the “idle” poor and encourage a “work discipline.” This system was continuous with the Mercantilist trends of the seventeenth century. Since we have seen Lettsom’s move to a Capitalist logic, the fact that he would dismiss this approach as a type of debilitating dependence is consistent with this rationality. Dean, The Constitution of Poverty: Toward a Genealogy of Liberal Governance.

226 Lettsom, "Hints Respecting the Distresses of the Poor," 10.
heightened degree of the dispensary’s attention given the disease’s widespread effects on the utility of the laboring population. Lettsom conceived of fever based on two criteria many epidemiologists commonly use to describe an epidemic.\textsuperscript{227} He recognized the diseases devastating impact and its general likeness among different individual cases:

In every part of the world, where records of physic have been preserved, putrid fevers, or those attended with symptoms of putrescency, have been distinguished by their violence and fatality; as well as by the uniformity of those symptoms they almost universally exhibit.\textsuperscript{228}

This assessment justified why fever ought to be an important object of medical knowledge, but did not explain why it legitimated a charitable response. As did other institutions operating within the regime of biopolitics, dispensaries addressed fever as though it were endemic in character.\textsuperscript{229} Fever, whether fatal or temporarily debilitating, was an expected outcome of the lifestyle of the poor. As we saw in chapter one, Lettsom asserted, “a long continuance of health is the lot of few.”\textsuperscript{230} Thus, the perceived duty to treat disease involved the static environment that shaped the sensibilities of the poor.

Lettsom saw the role of the dispensary physician to provide the poor patients not only with treatment, but advice to alter aspects of the environment itself. Lettsom

\begin{footnotes}
\item[227] An epidemic is often defined as the occurrence of a number of like cases within a community above the usual prevalence. Judith Mausner and Shira Kramer, \textit{Epidemiology: An Introductory Text} (Philadelphia: W.B. Saunders Company, 1985), 23.
\item[228] Lettsom, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and 1774," 1-2.
\item[229] Foucault, \textit{Society Must Be Defended}: \textit{Lectures at the College De France 1975-76}, 244.
\item[230] John Lettsom, "Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 " (London: Printed by H. Fry, 1797), 3.
\end{footnotes}
addressed these physical causes through his educational schemes. For example, Lettsom remarked,

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\text{[i]n the space of a very few years I have observed a total revolution in the conduct of the common people respecting their diseased friends; they have learned, that most diseases are mitigated by a free admission of air, by cleanliness, and by promoting, instead of restraining, the indulgence and ease of the sick.}^{231}
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Enacting these hygienic measures involved making changes to their living conditions, which may or may not have been attainable given the poor’s economic situation. Another dispensary physician in Manchester, John Ferriar, held a similar understanding of what these personal sanitary measures entailed. In an appendix he wrote for the poor to read as requested “by persons who are endeavoring to relieve [them] from the misery and fatality of other infectious diseases,” he incorporated tips to achieve cleanliness or fresh air that did not fit the lifestyle of the poor. For example, he wrote that the poor should “[a]void living in damp cellars” because of their detrimental effects and “[n]o temptation of low rents can counterbalance their ill effects.”\(^{232}\) Just like Ferriar, as historian Roy Porter notes, Lettsom “had a reputation for looking on the bright side.”\(^{233}\) However, other hygienic measures which more explicitly addressed the body proved more conducive to economic decisions.

Medical approaches addressed the body to deal with the environmental causes of disease, whether from miasma or contagious human effluvia. The body was seen as

\(^{231}\) Lettsom, "Of the Improvement of Medicine in London on the Basis of Public Good," 51.
\(^{232}\) John Ferriar, "Medical History and Reflections," (London: Cadell and Davis, 1798), 212.
both affected by the noxious air and able to transmit contagious effluvia itself.\textsuperscript{234}

Lettsom wrote that “there is a matter constantly exhaling from the human body, whether in health, or under disease” that was not usually pathogenic when in a “diluted state.”\textsuperscript{235} However, “this same effluvia, when accumulated in confined spaces, and for a considerable time retained about the body, acquire a virulence which often proves fatal to persons who receive the same, especially when these effluvia arise from people laboring under fevers, with symptoms of putrefaction.”\textsuperscript{236}

Introducing the poor to methods, such as changing their clothes or using windows, served as necessary prevention techniques also utilized by hospitals and other inpatient facilities.\textsuperscript{237}

The dispensary utilized other forms of education that treated the body as part of its environment. For example, the dispensary gave the poor an option to receive medical relief from a cheap source other than, what Lettsom considered, dangerous “quacks.”\textsuperscript{238} Lettsom explained how the poor’s “circumstances often compel them to make use of the first means of aid which specious pretenders offer them” and they consequently “fall victims to ignorance and quackery, and thereby forever impair their health, to the injury of their family and to the loss of the community.”\textsuperscript{239}

\begin{itemize}
\item \textsuperscript{234} J. V. Pickstone, “Ferriar's Fever to Kay's Cholera: Disease and Social Structure in Cottonopolis,” \textit{History of Science} 22(1984).
\item \textsuperscript{235} Lettsom, “Reflections on the General Treatment and Cure of Fevers,” 14.
\item \textsuperscript{236} Ibid.
\item \textsuperscript{237} Ibid.
\item \textsuperscript{238} Roy Porter, "'I Think Ye Both Quacks': The Controversy between Dr. Theodor Myersbach and Dr. John Coakley Lettsom,” in \textit{Medical Fringe & Medical Orthodoxy 1750-1850}, ed. W. F. Bynum and Roy Porter (Wolfeboro: Croom Helm, 1987).
\item \textsuperscript{239} Lettsom, "Of the Improvement of Medicine in London on the Basis of Public Good," 37.
\end{itemize}
individuals received necessary information from the Dispensary that could not be obtained otherwise.

Providing the necessities of life during illness also modified the economic dimension of the environment. Lettsom, in the wake of the severe winters of 1794 and 1795, described how the problems posed by the expenses of daily life were magnified when an individual considered “that by exposure to all weather, sickness often supervenes, and every resource is in a moment annihilated.”\textsuperscript{240} Thus, the weather led to a compromised site and rendered the price of these necessities problematic for the poor. For if the breadwinner was already struggling to maintain its economy, then imposing “an increased price of bread, beyond the reach of his earnings, supposing him capable of working, his misery is still inevitable without immediate aid.”\textsuperscript{241} Charitable intervention served to alter the environment’s negative effect on the individual. Lettsom explained how “few individual [were] so depraved as to become irreclaimable by kindness.”\textsuperscript{242} He continued, “[w]ere the plan, however, of early relief, once adopted, this hardened state would not be acquired; for depravity is not habitual, where oppression is not permanent.”\textsuperscript{243} He attributed the individual’s suffering to environmental conditions and saw immoral choices as structured within it.

\textsuperscript{240}———, “Hints Designed to Promote Beneficence, Temperance, and Medical Science: Volume 1 ”, 109.
\textsuperscript{241}———, "Hints Respecting the Distresses of the Poor."
\textsuperscript{242}Ibid., 13.
\textsuperscript{243}Ibid.
While Lettsom’s dispensary focused on the civilized individual, it also affected the public’s health. He evaluated the public benefit of the Dispensary against population measures like the Bills of Mortality.²⁴⁴ Lettsom recognized that “the London Bills of mortality have long been incorrect,”²⁴⁵ but considered them somewhat useful for demonstrating the positive effects of the dispensary. While he argued any “institution which contributes to the preservation of health, or the cure of disease cannot fail to produce some diminution in the bills of mortality,” the dispensary could be directly correlated “as the diminishment in the burials has been nearly progressive every year since it’s [sic] establishment.”²⁴⁶ The public success of the dispensary could not be attributed solely to “the relief which the poor have immediately received from this institution,” but also to “the useful instruction which, in every part of London, they have received from the physicians who have attended them during their illness, have greatly contributed to the preservation of lives, that might have been sacrificed to ignorance or quackery.”²⁴⁷ Thus, the involvement of the domestic environment had direct implications for the health of the public.

Not only was the dispensary intended to protect the public’s health through its educational services to the poor, but also through its advancement of medical knowledge. Lettsom saw the dispensary as affording a few useful opportunities from

²⁴⁴ Hardy describes the insufficiencies of these statistics for particular diagnoses. Anne Hardy, "Diagnosis, Death, and Diet: The Case of London, 1750-1809," *Journal of Interdisciplinary History* 18, no. 3 (1988).
²⁴⁵ Lettsom, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and 1774," 343.
²⁴⁶ ———, "Of the Improvement of Medicine in London on the Basis of Public Good," 50.
²⁴⁷ Ibid., 51.
offering additional training grounds for young physicians, to scheduling experienced physicians to offer public lectures each week, to providing the physician with a wide variety of medical cases for which they would publish reports.\textsuperscript{248} The necessity for this form of teaching institution given the number of factors seen to contribute to disease and the level of judgment required by the physician:

\begin{quote}
The difference in constitution, age, sex, state of air, manner of living, and such like circumstances will doubtless require the attention of physicians, and some occasional deviation or addition in the application of remedies, of which they ought to be competent judges; for I consider these reflections as mere outlines, which future observation and experience alone can properly fill up.\textsuperscript{249}
\end{quote}

The environment, composed of the air, mode of living and other factors had to be experienced first hand. As the dispensary helped “the healing art [advance] to maturity,” Lettsom argued, “the public must necessarily reap the benefit, by always meeting with accomplished guardians of health, under whose protection they might safely repose that dearest of temporal blessings.”\textsuperscript{250} This medical knowledge could be dispensed for both the affluent and the poor on the basis of the system of mutual obligation.

The charitable duty to promote the health of the poor was linked to both public and private dimensions. Using advice and medical relief to positively change the poor’s environment as soon as they fell into a debilitated state answered to their personal needs and helped ensure the nation’s prosperity. The dispensary, like other charities within the humanitarian domain, explicitly performed a dual function,

\textsuperscript{248} Ibid., 44.
\textsuperscript{249} ———, "Medical Memoirs of the General Dispensary in London, for Part of the Years 1773 and 1774," 11.
\textsuperscript{250} ———, "Of the Improvement of Medicine in London on the Basis of Public Good," 47.
serving both “humanity and policy.”

The preface of the Philanthropic Society of London, of which Lettsom was affiliated, wrote that in bridging the aims of “charity” with “industry and police” it would both offer “relief to a description of persons of all others to be most pitied” and “make it the interest of every individual to contribute to the support and extension of this Institution.” Thus, police functioned in a manner unlike our modern employment of the word. Rather than controlling crime, the humanitarian form of police functioned to maintain, or refine, the Capitalist order ensuring the welfare of society.

This concept of police framed the humanitarian project to immediately absolve the distress accompanied by poverty and disease. As we have seen, the dispensary sought to maintain the behavior of the poor in a manner that would sustain their productivity and thereby prevent them from falling into a state of poverty. The environment, given its etiological role in medical theory, guided the police work of the dispensary. Understanding “that conditions do not determine responses” is central to an account of the political nature of medical practice. Lettsom was concerned with the particular factors that impinged upon the economic independence of the

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255 Andrew describes this trend found within the Society for Bettering the Condition and Improving the Comforts of the Poor in 1795. “The underlying premise of the SBCP was that while the poor could maintain themselves, they needed great help in the administration and ordering of this maintenance.” Andrew, *Philanthropy and Police*, 174.
laboring poor. Thus, the environmental causes he identified as significant were those that left families unable to make choices to maintain their health in ways that allowed them to keep working. Since infectious diseases such as fever were endemic to the lifestyle of the poor, the fall into poverty was likely to occur for short periods of time.

Lettsom’s dispensary, endorsing a form police of the poor, did answer a form of social duty. Yet, this demand came from the poor’s right to labor rather than a principle of equal rights. Lettsom was concerned with the economic independence of the poor; therefore, the economic aspects of the environment, namely poverty, were seen as intimately related to disease and distress. Procuring the necessities of life was essential to a state of health. The way to intervene into the lives of the poor was not through political action, for the Capitalist system was not identified as the problem, but to remove distress by donating the necessary goods or effecting changes in the market. Most of Lettsom’s suggestions for the work of legislature directly relate to the functioning of the national economy, which though intimately connected to health, was not causally linked.257 Similarly, historian Roy Porter explains how many of the sanitary or civic reforms, such as street sweeping or installing lights, actually encouraged private business endeavors. Now Commissioners who were appointed by Parliament to make such improvements to the City engaged in contracts with a

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257 For example, Lettsom criticized legislation that limited barbers to utilize one portion starch and three portions flour for wig power; he argued this act would not lower the price of bread, and argued that desire to conserve starch was due to its use in beer and greasy meat, both habits that could be dispensed with. He recommended that the Legislature “at once, generously and humanely submit to forego the duties on starch, till the return of better times for the distressed poor.” Lettsom, “Hints Respecting the Distresses of the Poor,” 14.
variety of professionals to repair streets, collect garbage or perform other necessary tasks.\textsuperscript{258}

The dispensary is consistent with a humanitarian form of public health despite its private, charitable roots. While historian Peter Hennock claimed that the eighteenth-century public health movement existed, but had limited impact, he focused on the brief and sporadic establishment of governmental commissions.\textsuperscript{259} What makes the Dispensary consistent with such movements was its commitment to providing health as a matter of social duty. If any sort of “right” was being formulated, it was the right to work. More significantly, the dispensary raises the issue of public health’s connection to social justice. The humanitarian project to promote health was not based on universal social rights, and in protecting the health of the laboring class it actually preserved the pathogenic Capitalist enterprise. Social historians of medicine have championed the work of the State as the mark of medical humanitarianism. However, often those analyses prove blind to the historical developments necessary for the growth of the State.

\textsuperscript{259} E. P. Hennock, ”Urban Sanitary Reform a Generation before Chadwick?,” The Economic History Review, New Series 10, no. 1 (1957).
Conclusion

My study of the dispensary movement reexamined the concept of humanitarianism in the history of public health and medicine in England. Currently, historians acknowledge the role medical charities played in promoting the health of the poor. They often emphasize the continuities with the nineteenth-century campaign of the Sanitarians, explaining how many humanitarian physicians sought to ensure the lives of the poor by making changes to the environment in which they lived. Many environmental factors—from filth to diet to poverty—were seen as intimately related to disease. Improving the environment incorporated educational techniques to help the poor “escape” these debilitating conditions.260

The humanitarian acceptance of the causal connection between socioeconomic conditions and disease, according to many historians, marked a distinct difference from the next public health movement, which narrowly focused on the physical factors producing disease.261 W.P. Alison, a Scottish dispensary physician, is often cited as the ideal humanitarian reformer who was rooted in the ideas of the eighteenth-century because he posited the direct connection between destitution and disease. His disease theory challenged the assumptions of the political economy and

he advocated against the notions of the Sanitarians. For this reason, his “political medicine” has been portrayed as a forerunner of Virchow’s social medicine.\textsuperscript{262}

The above interpretation of the eighteenth-century public health movement often explains humanitarianism as a type of paternalism guided by general concerns for humanity.\textsuperscript{263} However, this historical view fails to dissect the humanitarian rationality in a manner that thoroughly explains how socioeconomic factors came to have an etiological significance. The humanitarian domain was concerned with treating the sick poor because it would promote public good. This public good was understood in terms of maintaining the nation’s economic prosperity, and ensuring the health of the laboring poor was valued as a means of repairing the damage done to the phenomenon of capitalist production. Given that the moral responsibility of both the rich and poor was understood in terms of their behavior in the market, the inequalities shaping the lifestyles of the rich and poor were not seen as problematic. The temporary distress produced by disease and poverty reflected a normal occurrence for the poor. This humanitarian form of public health arose not to prevent the occurrence of disease in individuals, but to promote the economic vitality of the nation. Making changes to the environment in order to adjust the lifestyles of the poor fit within this grander scheme.

I do not mean to condemn all forms of humanitarianism to promote health by demonstrating the close connection between medical charity and the economic world.


Rather, my study offers another example of why it is necessary to adopt a social justice approach to public health. Social determinants of health are constituted by the interaction of specific economic, political and cultural dimensions. These many layers of the environment structure a space in which the living being can rationally choose to function in ways that will promote health. In this view, patterns of inequality producing health disparities cannot but fall within the responsibility of public health. Engaging in epidemiological practice that merely explains the connection between socioeconomic structure and disease prevalence will not lead to improvements in health. In order to remove pathogenic inequalities, it is necessary for public health officials to advocate for social and economic rights.264

Reflecting on the dispensary model, the humanitarian domain often suppresses questions of inequality in the name of humanity. The concept of human rights still needs to be refined as a means of guiding the delivery of humanitarian assistance. Lettsom recognized the close connection between poverty and disease; concerned with the poor’s distress he established a charity to provide medical care. However, his effort to promote the public good nourished the capitalist enterprise. Charitable organizations making the commitment to work toward social and economic rights will directly assist the goal of public health: ensuring the conditions in which people can enjoy health. Foucault, in a call for human rights, emphasizes the significant contribution that private endeavors can make to fulfill this end:

Experience shows that one can and must refuse the theatrical role of pure and simple indignation that is proposed by us. Amnesty International, Terre des Hommes, and Medicins du Monde are initiatives that have created this new right—that of private individuals to effectively intervene in the sphere of international policy and strategy.265

Foucault recognizes that individuals must play a role in effecting change, participating in the public sphere in which governments have “attempted to reserve a monopoly for themselves.”266 The concern for health equity is no different.

Medical charity emphasizes that the humanitarian rationality ought to be revisited in order to participate in a form of public health that is consistent with a theory of social justice. Rudolph Virchow, the German physician who clearly outlined the principles of social medicine, endorsed a new understanding of medical humanism.267 Virchow argues that “Rightly understood, humanism is not an apotheosis of humanity, since this also would be anthropomorphic, but scientific self-knowledge, arising from the complexity of the relations between the individual thinking human being and the ever-changing world.”268 Adopting his view, the problem of disease can be framed as a demonstration of socioeconomic disparities. While the Whitehaven Dispensary celebrated its charitable endeavors during “an Age when SCIENCE and HUMANITY combine their influence to improve and felicitate

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266 Ibid.
267 Historian George Rosen outlines the principles of social medicine: that “society has an obligation to protect and insure the health of its members,” that science must be used to understand how social and economic factors cause disease and that “steps must be taken to promote health and to combat disease, and that the measures involved in such action must be social as well as medical.” Of course, he assigns the government with the role of fulfilling this social obligation. (1974, 64-67).
Mankind,” it does not adhere to Virchow’s notion of humanity.  

Humanitarian assistance ought to assist in the production of scientific knowledge that will support the advocacy work required of public health.

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