The Political Economics of English Psychiatry in the Early Twentieth Century

by

Akinobu Takabayashi

University College London

Thesis submitted to the University College London,

for the Degree of Doctor of Philosophy,

University of London

2008

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

I, Akinobu Takabayashi, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Abstract

The history of madness that has flourished over the past few decades has tended to concern itself with various aspects of institutionalisation, including that of the profession that would come to call itself psychiatry. As with the complementary literature on policy reform in this area, implicit in these accounts are attributions of humanitarian motives to the practice of psychiatrists. This thesis approaches the subject differently in order to challenge that assumption. It concentrates on the fledgling psychiatric profession in England around the turn of the twentieth century in order to bring out the political economic interests of those who sought to minister to the mentally challenged. It concentrates on the hitherto little-studied 1890 Lunacy Act, which it resurrects as pivotal in galvanizing the commercial interests of psychiatrists and as crucial to the subsequent development of the psychiatric profession through to the 1930s. The thesis explores the origins of the Act and its implications for the profession, before turning to the various rhetorical strategies deployed by psychiatrists in order to circumvent the Act's legal and commercial implications. The impact of the First World War on psychiatry is thus treated from a very different perspective than that usually derived from the focus on shell shock. The history and meaning of the reform of mental health legislation is also approached differently. The thesis draws on the membership of the Medico-Psychological Association for statistical and prosopographical qualification, and, in one chapter, focuses on the records of the Holloway Sanatorium in Surrey to instance the kinds of manoeuvres involved in admissions procedures to mental asylums consequent upon the 1890 Act. Throughout, the thesis seeks to illuminate

the politics of a profession seeking to gain control of the private sector in the trade in lunacy.

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Acknowledgments

I would like to thank the Graduate School of University College London for a two-year scholarship and the Wellcome Trust Centre for the History of Medicine for its generous funding, both of which enabled me to undertake this research. I also devote my sincere gratitude to my supervisors, Professor Roger Cooter and Doctor Michael Neve, and the former supervisor Professor Christopher Lawrence. I am most grateful to them for their guidance, criticisms and patience, especially to Roger's. I am proud of, and very pleased at, having been a student of Roger, a leading historian of medicine and a teacher who is worth challenging. Along with them, Professor Janet Browne and Doctor Helga Satzinger helped me greatly as Post Graduate Tutors. I would also like to thank Doctor Rhodri Hayward, Doctor Nandini Bhattacharya, Doctor Stephen Casper, Karen Buckle, Candice Delisle, Doctor Danny Leung, and Doctor Jorge Varanda for their invaluable comments, proof-reading, and friendly support. I am delighted to have such lifetime colleagues in the Centre. In the Centre, Sally Bragg has also helped me especially when I had troubles with my living in London. Without her, I would not have survived in London. My research is, I have to note, assisted kindly by a number of archivists of the Wellcome Trust Library, Surrey History Centre, London Metropolitan Archives, Parliamentary Archives, Royal College of Psychiatrists Archives, National Archives, Centre for Kentish Studies, University College London Hospital Archives, St. Bartholomew's Hospital Archives, St. Mary's Hospital Archives, and Planned Environment Therapy Trust Archive. I am also obliged to Professor Yasushi Aoki and Professor Akihito Suzuki for their encouragement. Finally, I devote my thesis

to Kazumi Hirano and my parents Masahiro and Hiroko, all of who have supported me for these three years.

Introduction

1. Histories of Modern Psychiatry in England

This dissertation contributes to a history of the political economics of English psychiatry, through a focus on the impact of the Lunacy Act of 1890 on the profession to the 1930s. By 'psychiatrists,' I mean medically qualified doctors who identified themselves as experts in mental diseases, and who had membership in such professional organisations as the Medico-Psychological Association (MPA). Most of them had working experience in mental health institutions, and tended to refer to themselves around the turn of the twentieth century as 'alienists' or 'medical psychologists.'[1] For convenience, I use the term 'psychiatrists.'

Scholarship in the history of English psychiatry has flourished over recent decades. Its major focus has been on the role of psychiatrists in making mental health policies, on the mad-doctoring trade, and on the mass confinement of the insane in pauper lunatic asylums in the eighteenth and nineteenth centuries. In 1960, Kathleen Jones, a social policy historian, argued that modern English psychiatrists contributed to the evolution of mental health policy.[2] Her faith was in the scientific

[1] Mathew Thomson argues that the boundary of the early twentieth-century psychiatric profession was still blurred (Mathew Thomson, *The problem of mental deficiency: eugenics, democracy, and social policy in Britain c.1870-1959*, Oxford: Clarendon Press, 1998, p. 112). This seems to some extent true, because psychiatrists could not establish an clear jurisdiction through an exclusive licence of their own and their educational backgrounds ranged widely. However, surely, there were doctors who defined themselves as a specific occupational group like 'alienists' and 'medical psychologists,' based on their specific experiences in dealing with mental patients usually at asylums.

[2] Kathleen Jones, *Mental health and social policy 1845-1959*,London: Routledge & Paul, 1960; Kathleen Jones, *Asylums and after: a revised history of the mental health services from the early 18th century to the 1990s*, London: Athlone, 1993.

and humanitarian credentials of psychiatrists. In 1972, the historian of psychiatry and psychiatrist William Ll. Parry-Jones emphasised the importance of economic factors in developing professional care for the mad, the so-called 'trade of lunacy' of the eighteenth and nineteenth centuries.[3] In 1979, Andrew Scull, an America-based sociologist of modern psychiatry, contended that the psychiatric profession increasingly monopolised and transformed the mad business into the controlling of a socially useless population.[4] The history of modern psychiatry was thus the history of professional development.

Throughout the 1980s and 1990s, such pioneering studies underwent careful scrutiny by social historians. Roy Porter, for instance, examined the medical and popular culture behind the development of professional psychiatry and attempted a retrospective restoration of the patient's experience as a lunatic to accomplish a 'history from below.'[5] In Porter's train, a number of social historians produced studies that highlighted the importance of poor law, gender, patients' families and regional differences - not professionals.[6]

In the light of this revisionist literature, this dissertation may seem old-fashioned, since it is concerned with the politics and economics of the psychiatric profession. But this focus stems from a historiographical lacuna, the fact that

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[3] William Ll. Parry-Jones, *The trade in lunacy: a study of private madhouses in England in the eighteenth and nineteenth centuries*, London: Routledge and K. Paul, 1972.
[4] Andrew Scull, *Museums of madness: the social organization of insanity in 19th century England*, London: Allen Lane, 1979; Andrew Scull, *The most solitary of afflictions: madness and society in Britain, 1700-1900*, New Haven: Yale University Press, 1993.
[5] Roy Porter, *Mind-forg'd manacles: a history of madness in England from the Restoration to the Regency*, London: Athlone, 1987.
[6] Joseph Melling and Bill Forsythe, *The politics of madness: the state, insanity, and society in England, 1845-1914*, London: Routledge, 2006; Peter Bartlett and David Wright (eds), *Outside the walls of the asylum: on "care and community" in modern Britain and Ireland*, New Brunswick; London: Athlone Press, 1999; David Wright, 'Getting out of the asylum: understanding the confinement of the insane in the nineteenth century,' *Social History of Medicine*, Vol. 10, 1997, pp. 137-155; Roy Porter and David Wright (eds), *The confinement of the insane: international perspectives, 1800-1965*, Cambridge: Cambridge University Press, 2003; Pamela Dale and Joseph Melling (eds), *Mental illness and learning disability since 1850: finding a place for mental disorder in the United Kingdom*, London; New York: Routledge, 2006.

professional politics have been examined only in relation to morals and ideologies, not economics. This historiographical gap is particularly obvious in the study of early twentieth-century psychiatry which has been framed in terms of humanitarianism and the medico-political ideology of mental hygiene, as bounded by the Lunacy Act of 1890 and the Mental Treatment Act of 1930.

Kathleen Jones has described the 1890 Act as a 'triumph of legalism' because it provided tight legal control over psychiatric admissions. She sees it as causing a decline in standards of care, and in treatment and scientific research, as well as stigmatising patients by means of its legalistic admission systems.[7] For these reasons, she explains, 'asylum doctors were moving towards a more humane system' of psychiatric admissions after 1890.[8] This professional altruism, she argues, framed the 1930 Act that reinstated admission systems that did not require legal supervision, and also garnered new medical facilities at outpatient clinics.[9] This interpretation has ruled in history for over thirty years.[10]

Clive Unsworth, a sociologist of law, on the other hand, has explained the policy formation of psychiatry in terms of its intellectual history. From this

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[7] Kathleen Jones, *op.cit.*, 1960, p. 40; Kathleen Jones, *op.cit.*, 1993, pp. 112-114. Peter Nolan also argued that the 1890 Act did not provide any progress to mental nursing; rather it made nursing primarily a job of controlling asylum inmates (Peter Nolan, 'Mental health nursing in Great Britain,'German E. Berrios, Hugh Freeman (eds), *150 years of English psychiatry, Volume 2: the Aftermath*, 1996, p. 179). In terms of education and training, too, the 1930 Act was described as a basis for modern psychiatry (John L. Crammer, 'Training and education in British psychiatry, 1770-1970,' *ibid.*, p. 229).

[8] Kathleen Jones, *op.cit.*, 1993, p. 112.

[9] Kathleen Jones, 'The culture of the mental hospital,' German E. Berrios, Hugh Freeman (eds), *150 years of English psychiatry, 1841-1991*, London: Gaskell, 1991, p. 23.

[10] Kathleen Jones, 'Law and mental health: sticks or carrots,' German E. Berrios, Hugh Freeman (eds), *op.cit.*, 1991, pp. 95-97; Edward Renvoize, 'The Association of Medical Officers of Asylums and Hospitals for the Insane, the Medico-Psychological Association, and their Presidents,' German E. Berrios, Hugh Freeman (eds), *op.cit.*, 1991, p. 66; Mathew Thomson, '"Though ever the subject of psychological medicine": psychiatrists and the colony solution for mental deficiencies,' German E. Berrios, Hugh Freeman (eds), *op.cit.*, 1996, p. 137; Malcom Pines, 'The development of the psychodynamic movement,' German E. Berrios, Hugh Freeman (eds), *op.cit.*, 1996, pp. 206-231; John L. Crammer, 'Training and education in British psychiatry, 1770-1970,' *ibid.*, p. 211; Suzanne Raitt, 'Early English Psychoanalysis and the Medico-Psychological Clinic,' *History Workshop Journal*, Issue 58, 2004, pp. 63-85.

perspective he argues that English psychiatry materialised its therapeutic and preventive approaches to mental diseases in the 1930 Act, influenced by the non-psychiatric thoughts centred on public health and national efficiency.[11] For him, psychiatric policy was not a product of psychiatrists alone, but a reflection of its ideological times.

This dissertation argues that these histories overemphasise the autonomy of the professional culture of psychiatry and lay too much weight on intellectual factors over basic economic ones and, above all, personal and collective financial interests. In saying so, however, it should be noted that historians of English psychiatry have carefully highlighted not only intellectual factors but also other multi-factorial dimensions.[12] The thesis therefore charts the history of these interests, while seeking to avoid crude economic reductionism. It is offered less as a revision of the existing literature than a supplement to it.

2. The Theory of Professionalisation

The American sociologist Andrew Abbott provides a good starting point for the study of the political economy of a profession.[13] In elaborating a sophisticated model of professional development, Abbott paid attention to sub-divisional factors:

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[11] Clive Unsworth, *The politics of mental health legislation*, Oxford: Clarendon Press; New York: Oxford University Press, 1987, p. 210; p. 229.

[12] For example, Melling and Forsythe argue about the psychiatric history, including such focuses as local economy, gender, the poor-law and class (Joseph Melling and Bill Forsythe, *op.cit,* 2006). Other historians of psychiatry also have carefully paid attention to multi-factors in making modern English psychiatry. See Peter Bartlett, *The poor law of lunacy: the administration of pauper lunatics in mid-nineteenth century England,* London: Leicester University Press, 1999; Akihito Suzuki, *Madness at home: the psychiatrist, the patient, and the family in England, 1820-1860*, Berkeley; London: University of California Press, 2006.

[13] Andrew Abbott, *The system of professions: an essay on the division of expert labour*, Chicago: University of Chicago Press, 1988.

disturbances in a professional jurisdiction,[14] internal divisions of labour,[15] the workplace,[16] jurisdictional claims, and jurisdictional settlement.[17] In particular, jurisdiction was a key concept. By 'jurisdiction,' he meant 'the link between a profession and its work,' though in effect he uses the term to describe a virtual sphere in which a profession can monopolise (or maximise the material interest in) particular clients.[18] Clients represent an economic boundary that professions aspire to enclose. Professional development is, Abbott argued, generated by a disturbance in the existing jurisdiction of a profession that brings changes to the professional internal structure and workplace. Such a change leads a profession to re-create its political claim for reviving the control of its jurisdiction. This model outlines a direction for this study of the political economic history of the psychiatric profession in Britain where, arguably, a key 'disturbance' was the 1890 Lunacy Act.

3. The Economy of the Lunacy Act of 1890

The 1890 Act was an economic disturbance to the existing jurisdiction of psychiatrists.[19] In particular, this was caused by the Act's restriction on further expansion of, and judicial supervision over, the private sector in psychiatric care.[20] Psychiatrists in that sector, unlike other medical professionals, were not allowed to operate practices free from state regulation. Importantly, the private sector

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[14] *Ibid.*, pp. 86-96.
[15] *Ibid.*, pp. 79-85; pp. 118-120.
[16] *Ibid., pp.* 125-129.
[17] *Ibid.*, pp. 59-79; pp. 98-104.
[18] *Ibid.*, p.20.
[19] Charlotte Mackenzie, *Psychiatry for the rich: a history of Ticehurst Private Asylum, 1792-1917*, London; New York: Routledge, 1992. See *Ibid*, p. 204.
[20] *Lunacy Act,* 53 Vict., 1890, Ch. 5.

represented only ten-percent of the patient population in asylums but provided most of the profession's earnings - between approximately seventy and ninety-percent of that of senior psychiatrists.[21] For this reason, after 1890, psychiatrists were concerned primarily with regaining professional control over the private sector.

The private sector consisted of private asylums operated by either lay or medical proprietors for personal gain, as well as registered hospitals run principally for charitable purposes.[22] The public sector, on the other hand, was constituted by county and borough asylums run by local authorities. It provided appointments for aspiring psychiatrists, but at the lower end of the profession and usually only short-term.

This thesis poses the question. In what ways did the 1890 Act exert an economic impact on the psychiatric profession? How did the profession reconstruct rhetoric, career making, institutional practice and inter-professional competition in response to the economic threat of the Act? In addressing these matters, the thesis argues that the 1890 Act forced English psychiatrists, especially senior doctors working in the private sector, to revive the private sector through consulting practice, a voluntary admission system, and a new political rhetoric around 'early treatment of mental disorder.'[23] All these measures were designed to maintain the professional jurisdiction of psychiatry.

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[21] See Section 4 in Chapter 3.

[22] There were 82 private asylums and 14 registered hospitals in England and Wales in 1890, while public asylums were 67 (*Annual Report of the Commissioners in Lunacy*, 1890).

[23] Louise Westwood has described the idea of early treatment as a humanitarian and progressive movement of English psychiatrists (Louise Westwood, 'A quiet revolution in Brighton: Dr Helen Boyle's Pioneering Approach to Mental Health Care, 1899-1939,' *Social History of Medicine*, Vol. 14, 2001, pp. 439-457).

4. Organisation of the Thesis

The thesis is divided into six chapters running from the economic impact of the Lunacy Act of 1890 on the psychiatric profession and its jurisdiction, to the political economic outcome on the profession in the 1920s.

Chapter 1 opens with the 1890 Act and its economic disturbance to the psychiatric profession. The Act's restriction on private business of psychiatry and the establishment of legal control over psychiatric admissions is outlined. Frustrated psychiatrists campaigned for new legislation to defend their economic interests. The chapter also details the various provisions that the Act introduced in order to safeguard patients' rights and not to prolong institutional detention. These provisions show, in contrast both to historical and contemporary psychiatric views, that the 1890 Act was not entirely inhumane legislation.[24]

Chapter 2 analyses how the profession constructed its political claims for the amendment to the 1890 Act. The claims were written around rhetoric for a humane and therapeutic psychiatry: early treatment of mental disorder. Through this rhetoric, psychiatrists criticised the allegedly non-therapeutic and inhumane nature of the 1890 Act and proposed alternative legislation to establish general hospital psychiatry and voluntary admissions without legal intervention. They varnished over their economic interests in the private sector.

Behind the political rhetoric for the early treatment of mental disorder was the economic impact of the 1890 Act on the private practices of psychiatrists. To uncover this, Chapter 3 draws on the membership lists of the Medico-Psychological

[24] [24] Kathleen Jones, *op.cit.*, 1960, p. 40; Kathleen Jones, *op.cit.*, 1993, pp. 112-114.

Association as published in 1890 and 1914.[25] Together with information from medical directories, the chapter statistically reconstructs the occupational structure and career patterns of psychiatrists, indexing the wealth and working places of psychiatrists, as well as their regional and social distribution. For an analysis of their individual wealth, it also draws on *Probate Calendars*. Through a statistical examination of the personal finances of psychiatrists, this chapter argues that the restriction on psychiatrists' private businesses made it difficult for them to promote their status and to finance themselves in the private sector. As a result, I argue, they were led to remake their career patterns. They became mental consultants: elite psychiatric doctors operating private practices for the middle and upper classes. To manage this business successfully, however, vital was an appointment in a general hospital where private clients could be recruited. For this reason, the thesis concludes that the political claim for general hospital psychiatry was self-interested.

From the viewpoint of the economic impact of the 1890 Act, Chapter 4 explains why psychiatrists advocated the voluntary admission of mentally ill patients into asylums. To analyse the admission system, it draws on the records of the Holloway Sanatorium and the exposes in the journal *Truth* published by Henry Labouchere (1831-1912), a radical Liberal MP. While the latter provides a wealth of evidence of abuses in the Holloway's management of voluntary admission, the former proves the allegations to be largely true. The evidence is also supported by the official reports of the Lunacy Commissioners and the Home Office. Through these sources, the chapter argues that the legal certification incorporated in the 1890 Act forced psychiatrists to adapt their workplaces to client demands for a less legalistic admission system of voluntary admission. The new system was, for

[25] As for the MPA and its senior members, see German E. Berrios, Hugh Freeman (eds), *op.cit.*, 1991; German E. Berrios, Hugh Freeman (eds), *op.cit.*, 1996.

psychiatric institutions and doctors, an institutional instrument to survive in the 'mental health market' of the 1890 Act.

The post-1890 economy of English psychiatry was influenced significantly by the Great War. Chapter 5 documents how the psychiatric profession responded to the politico-economic changes that the war brought with the problems of shell shock. Many historians have studied shell shock, but few have referred to its politico-economic significance for the psychiatric profession.[26] This chapter argues that the war enabled psychiatrists to justify their opposition to the 1890 Act, assisted by public and parliamentary opinion that opposed shell-shocked soldiers being certified legally as a lunatic and detained in lunatic asylums. But, at the same time, the war introduced non-psychiatrist doctors, especially neurologists, into practices of mental diseases. Increasing professional rivalry in the mental health market further framed the post-war political economics of English psychiatry.

The concluding Chapter 6 argues how all these changes conspired to the making of English psychiatry in the 1920s and therefore that histories written with the 1930 Mental Treatment Act more in mind need considerable revision.[27] Concentrating on the 1920s, this chapter revisits earlier themes: the idea of the early treatment of mental disorder; the professional structure and career making of psychiatrists; the institutional practice of voluntary admission; and the inter-

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[26] Martin Stone, 'Shellshock and the psychologists,' in William Bynum, Roy Porter, and Michael Shepherd (eds), *The anatomy of madness: essays in the history of psychiatry*, London, 1985, pp. 242-271; Peter Jeremy Leese, *Shell shock: traumatic neurosis and the British soldiers of the First World War*, Basingstoke: Palgrave Macmillan, 2002; Ben Shephard, *A war of nerves*, London: Jonathan Cape, 2000; Peter Barham, *Forgotten Lunatics*, London: Yale University Press, 2004. See the special Issue of *Journal of Contemporary History* on shell shock published in 2000, specially Jay Winter, 'Shell-Shock and the Cultural History of the Great War,' *Journal of Contemporary History*, Vol. 35, No. 1, 2000, pp. 7-11; Mark S. Micale and Paul Lerner (eds), *Traumatic pasts: history, psychiatry, and trauma in the modern age, 1870-1930*, Cambridge: Cambridge University Press, 2001.

[27] Kathleen Jones, *op.cit.*, 1993, pp. 126-127; Patricia Allderidge, 'The foundation of the Maudsley Hospital,' German E. Berrios, Hugh Freeman (eds), *op.cit.*, 1991. As for the rush of the establishment of psychotherapeutic clinics in the 1920s, see Nikolas Rose, *The psychological complex: psychology, politics and society in England, 1869-1939*, London: Routledge, 1985, pp. 197-219.

professional collaboration and conflicts between psychiatrists and other doctors engaged in the treatment of mental and nervous diseases. This post-war history derives from a wide range of official and institutional records, including those of general and neurological hospitals, homes for shell-shocked soldiers, and private nursing homes. Utilising these sources, this chapter argues that, based on the principal idea of the early treatment of mental disorder, psychiatrists configured a new political and economic order, the one characterised by private consultancy and voluntary admissions. They pursued economic survival in the arena of inter-professional competition in which they could have a medical practice free from the state regulation and closer to clients' demands. Hence, the thesis argues that the politics of early twentieth-century English psychiatry was concerned significantly with its self-interests, along with altruistic professionalism and ideology as it was explored by the previous historians.

Chapter One. The Lunacy Act of 1890

Introduction

The Lunacy Act of 1890 has been overlooked in the history of English psychiatry. It has been read only in terms of its major provision, that of legal certification for psychiatric admissions. Its economic implication have not been seriously considered. The legal controls of the Act have been interpreted by Kathleen Jones, along with historians, as interference in the implicitly progressive therapeutic regime of psychiatry.[1] This thesis re-reads the Act as an external disturbance to the economic jurisdiction of the psychiatric profession, specifically focusing on its legal certification claims and its prohibition of issuing new licences for private asylums.

1. The Origin of the Lunacy Act of 1890

Behind the 1890 Act were scandals of wrongful confinement of allegedly sane citizens in private asylums. Between the 1860s and 1880s, sensational news of this sort attracted public attention. Among them, notable was a Mrs. Weldon who was allegedly confined in a private asylum without her consent in 1884.[2] After being discharged, Weldon took legal action against both her husband, who had made the

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[1] Kathleen Jones, *op.cit.*, 1993, pp. 93-106.

[2] *Ibid.* Peter McCandless, 'Liberty and lunacy: the Victorians and wrongful confinement,' in Andrew Scull (ed.), *Madhouses, mad-doctors, and madmen: the social history of psychiatry in the Victorian era*, London: Athlone Press, 1981, pp. 339-362. Clive Unsworth, *op.cit.*, pp. 80-81.

petition for her admission, and the doctors who had signed the medical certificates of her insanity. Her case was sensational. Newspapers and quality journals urged a political move for new legislation, and reproached psychiatrists for 'unfair' confinement.[3] The political movement against the 'trade of lunacy' was supported by such voluntary associations as the Lunacy Law Association, the Lunacy Law Amendment Society, and the National Association for the Defence of Personal Rights. These bodies insisted on the necessity of providing further legislative safeguards for the liberty of the English subject.[4] These political events, the historian Clive Unsworth has argued, were initiated by the legal profession that perceived the scandals as an opportunity to undermine the professional grounds of psychiatry.[5]

For psychiatrists, the scandal was simply embarrassing. In a retrospect of 1902, Charles Mercier (1852-1919), the proprietor of the Moorcroft private asylum in London, and late medical superintendent of the City of London Asylum, wrote:

> In 1884 there occurred a cause *celebre*... A certain lady – a very attractive lady, a very clever lady, and somewhat eccentric lady (Mrs. Weldon) – was considered by her friends to be a proper person to be detained under care and treatment; and they applied to Dr. Winslow to aid them in this respect. He made the attempt, and the attempt failed. It failed disastrously and ignominiously, and Mrs. Weldon remained mistress of the situation. She brought actions in the Court of King's Bench against Dr. Winslow, against Dr. Semple, against Sir Henry de Bathe, and she was awarded £500 damages against Dr. Winslow, £1,000 against Dr. Semple, and, I think, another £1,000 against Sir Henry de Bathe. Well, the public clamoured for an alteration in the law. They said that the law was not strong enough; that anybody might be seized and taken to an asylum under the law as it existed. They seemed to

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[3] *Times,* March 18-25, 1884; *Ibid,* July 29, 1884, p. 9; *Ibid,* October 3, 1884, p. 5. Also see *Lancet,* March 22, 1884, p. 536; *Ibid,* p. 541; *Ibid,* August 2, 1884, p. 215.
[4] Clive Unsworth, *op.cit.*, pp. 93-96.
[5] *Ibid.*, pp. 96-100. The legal professionals might have little hostility toward, and competition with, the medical profession, since they in some cases recruited doctors as clients (*Law Quarterly Review,* 114, 1913, p. 182).

> imagine that asylums sent out pressgangs in order to knock people down in the streets and carry them off to asylums.[6]

Public opposition to the scandal led parliamentary legislators to consider new legislation. In 1877 the House of Commons appointed a Select Committee on the Operation of the Lunacy Law. The Committee was expected to consider restrictions on psychiatric practices to safeguard the liberty of the English subject. But, beyond expectations, its concluding report sympathetically expressed general satisfaction with the existing legislation.[7]

Despite the outcome, the Lord Chancellor drafted a bill that concentrated on legal restrictions on psychiatry. This discrepancy was, Unsworth has suggested, caused by the Lord Chancellor Lord Halsbury, Hardinge Stanley Giffard (1823–1921), a politician who considered the rule of law above that of professionalism, and believed that 'there was no room for specialist decision-making in the process of commitment.'[8] Probably for this reason, Halsbury introduced his radical bill of 1887 and 1888,[9] which finally passed through Parliament as the Lunacy Amendment Act of 1889 and which in 1890 was consolidated into the Lunacy Act – a law that shaped English psychiatry for the next forty years.[10]

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[6] *Journal of Mental Science*, January, 1903, p.200.
[7] *Report from the Select Committee on Lunacy Law*, H.M.S.O., 1877, pp. 1-2.
[8] Clive Unsworth, *op.cit.*, p. 83.
[9] As this chapter goes on to show, after 1890, Halsbury increasingly changed his attitudes to allowing amendments to the 1890 Act.
[10] *Journals of the House of Lords*, Vol. 72, 1889; *Journals of the House of Commons*, Vol. 145, 1890.

2. Reconsideration of the Lunacy Act of 1890

The 1890 Act mainly affected the private sector in psychiatry. The Act had 12 parts to it, and 342 sections, none of which significantly altered admission procedures for pauper or criminal lunatics. Its main purpose was to establish legal control over psychiatric admissions of private patients, to reinforce legal safeguards against wrongful confinement and improper treatment for patients, and to suspend the issue of new licences to private asylums.[11]

The private sector of the English mental health service consisted of 82 private asylums run for profit, together with 14 charitable hospitals for lunatics registered under the Lunacy Laws. The former were run mainly by medical proprietors, the latter voluntary institutions administered by lay governors.[12] In 1889, these institutions accommodated 6,812 private patients and 1,157 pauper patients, about ten percent of the inpatient population as a whole. In the same year, the public sector amounted to 66 county, borough and city asylums that provided treatment and care for 50,709 patients, about 60 percent of the total of incarcerated psychiatric patients. In addition, Poor Law workhouses accommodated to 17,509 pauper patients, while single and home care provided the rest.

Legal Certification

Legal control over psychiatric admission was exercised mainly through the 'reception order.' This was peculiar to the 1890 Act; before 1890, the Lunacy Act

[11] The Act did not affect the laws relating to Scotland and Ireland.
[12] The medical proprietors were approximately three-fourth of all the proprietors.

of 1845 required only two medical certificates signed by qualified medical doctors in order to confirm a patient who needed psychiatric admission.[13] The 1890 Act by contrast required a judicial order, in addition to a medical certificate.[14] The legal requirement was generally referred to as 'legal certification.'[15]

In creating the reception order, the 1890 Act established the 'judicial authority' over medical certification and an application made by patient's relatives or friends.[16] By 'judicial authority,' the law meant responsibility possessed by a justice of the peace specially appointed or a county court judge, or a magistrate having jurisdiction in the place where the lunatic resided.[17] The responsibility was noted in the statute and in legal journals and handbooks, although it seems that many judges were unconcerned about the duties that the Act imposed on them.

The procedure for the reception order began with a petition. The Act provided that it was to be presented, 'if possible, by the husband or wife or by a relative of the alleged lunatic.'[18] It added that if relatives did not present the petition, the petitioner should make a statement of the reasons why the petition was not so presented and of the connexion of the petitioner with the alleged lunatic.[19] This loose rule was a loophole in the law; the clause allowed asylum managers later to apply to voluntary patients certification as a lunatic without contacting their relatives.

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[13] On medical certificates of lunacy before 1889, see Peter Bartlett, 'Legal madness in the nineteenth century,' *Social History of Medicine*, Vol. 14, 2001, pp. 107-131; David Wright, 'The certification of insanity in nineteenth-century England and Wales,' *History of Psychiatry*, Vol. 9, 1998, pp. 267-290.
[14] By private patients, the English Lunacy Laws meant those who could pay an expense charged by institutions by themselves; on the other hand, pauper patients referred to those who were dependent on local boards of guardians in terms of asylum fees.
[15] See Section 6(2) (*Lunacy Act, 1890, 53 Vict., CH5*).
[16] *Lunacy Act, 1890, 53 Vict., CH5*. Also see James William Greig and William H. Gattie, *Archbold's lunacy and mental deficiency: comprising the Lunacy Acts, 1890-1911, the Lancashire County (lunatic asylums and other powers) Acts, 1891 and 1902, the Mental Deficiency Act, 1913 and all the statutory rules, orders and forms in force thereunder, the statutes relating to criminal lunatics, the Lunacy (vacating of seats) Act, 1886, and the Asylums Officers' Superannuation Act, 1899*, London: Butterworth & Co., 1915, pp. 142-143.
[17] *Lunacy Act, 1890, 53 Vict., CH5*, p. 21; James William Greig and William H. Gattie, *op.cit.*, pp. 143-146.
[18] *Lunacy Act, 1890, 53 Vict., CH5*, p. 18.
[19] *Ibid.*

The medical certificates attached to the petition required the signature of two medically qualified doctors, who were independent in practice, and not relatives of the patient and petitioner. No regular medical attendant in an institution could sign a certificate of lunacy.[20] These tight restrictions were meant to be safeguard against personal gain and 'any person interested in the payments on account of the patient.' Of two certifying doctors, though, one was allowed to be a family doctor who knew the patient,[21] but each certifying doctor had to see the patient independently of another.

The reception order was valid only for a specific period. To keep the order valid, asylum managers had to submit a special report to the Lunacy Commissioners at the end of the first year of the patient's reception, and subsequently every two, three and five years. Chronic patients, however, were often forced to stay for substantially longer periods than the Act prescribed.

Overall, the Act stressed the legal nature of psychiatric admission. The reception order clause stated that 'a person...shall not be received and detained as a lunatic in an institution for lunatics, or as a single patient, unless under a reception order made by the judicial authority.'[22] Because of this distinctive feature, psychiatrists' clients resorted to formal psychiatric admissions only when they could not avoid doing so, as Chapter 4 will argue.

The procedure for the reception order provided a penalty clause for those who received psychiatric patients without legal certification. Section 315 stated that:

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[20] *Ibid.*
[21] *Ibid,* p. 32.
[22] *Ibid,* p. 17.

> If a doctor received a lunatic or alleged lunatic in an institution for lunatics or unlicensed houses for payment, the doctor should be guilty of a 'misdemeanor,' and might be liable to a penalty not exceeding fifty pounds.[23]

This clause became notorious among English psychiatrists by the mid-1890s, although the Lunacy Commissioners in fact prosecuted only a few cases of lay proprietors of private nursing homes.

Minor Admission Measures

Besides the reception order, the Act provided an 'urgency order' that allowed private patients, whose symptoms necessitated immediate treatment, to enter registered hospitals or private asylums within seven days only with a medical certificate and family member's application.[24] This emergency measure was often applied to patients who needed a probationary period before the formal reception order.[25] Hence, this 'halfway' admission system was not regarded by psychiatrists as relaxing the tight regulation around the reception order.

Voluntary admission was the other system that allowed private psychiatric institutions to receive alleged but mild cases of mental disease, the so-called 'boarders.'[26] Such cases were admitted with the consent of two Lunacy Commissioners or two justices of the peace with the power to license a private asylum. This was granted by the Lunatics Act Amendment Act of 1862. This

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[23] See Section 315 (*Ibid,* p. 142).
[24] *Ibid,* p. 23; Clifford Allbutt and Humphry Davy Rolleston (eds.), *A system of medicine*, Vol. 8, 1911, p. 1041.
[25] Peter McCandless has argued that 'urgency order' was expected to satisfy psychiatrists who wished 'quick committal of acute cases' (Peter McCandless, 'Dangerous to themselves and others: the Victorian debate over the prevention of wrongful confinement,' *Journal of British Studies*, 1983, p. 104).
[26] See Section 229 (*Lunacy Act, 1890, 53 Vict., CH5*).

legislation imposed the condition that boarders should be those who had been previously detained as a lunatic in asylums. Contemporary psychiatrists insisted that this conditional regulation prevented the use of asylums. By abolishing that conditional clause, the 1890 Act improved the availability of voluntary admission. The legislators expected it to satisfy psychiatrists who complained about the legalism established by the 1890 Act. This informal admission system, however, did not please psychiatrists entirely, since it required the consent of the Lunacy Commissioners in advance. Hence, after 1890, psychiatrists sought deregulation of the voluntary admission system.[27]

Legal Safeguards for Wrongful Confinement and Ill-treatment

The 1890 Act not only forced legal admission on psychiatric patients, but included measures to prevent the wrongful, inhumane and prolonged detention of patients. Section 6, for example, stipulated that judicial authority should 'consider the allegations in the petition and statement of particulars and the evidence of lunacy appearing by the medical certificates.'[28] If not being satisfied with the submission, the justices could visit the alleged lunatic and hold an individual interview. Patients were also guaranteed the right to appeal against such justices and magistrates,[29] 'to request personal and private interview with a visiting Lunacy Commissioner or

[27] Chapter 4 will precisely examine the institutional practice of voluntary admissions under the 1890 Act.
[28] *Ibid*, pp. 18-19.
[29] *Ibid.*

visitor at any visit which may be made to the institution,' and to send a letter to the Lunacy Commissioners.[30]

The Commissioners in Lunacy were the government's agents under control of the Lord Chancellor and Home Office. They were appointed initially after the Lunacy Act of 1845 to inspect asylums for the welfare of mentally ill patients. In addition to asylum inspection, they issued licenses to metropolitan asylums and drew up statistical reports. They consisted of three medical and three legal professional inspectors paid £1,500 per annum plus travelling expenses.[31] Not surprisingly, the high salary attracted asylum superintendents. In recruiting them over the years, the Commissioners tended to become cooperative functionaries with psychiatrists, not a watchdog of the trade of lunacy strictly.[32]

To prevent the wrongful confinement and ill-treatment of patients, the 1890 lunacy legislation required asylum doctors to make monthly reports on patient admissions to the Commissioners.[33] Simultaneously, the doctors working in private asylums licensed by local justices had to submit reports to the visiting committee from the local authorities. On the basis of that report, state and local authorities were to visit patients at the earliest opportunity. During the visit, they had to observe institutional management, buildings, admissions and discharges, divine services, the classification of patients, occupational treatment, amusements, diet, as well as bodily and mental conditions.[34]

More regulations were elaborated for guaranteeing the humanitarian treatment of patients. The specific target was mechanical restraint, a traditionally

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[30] *Ibid*, pp. 34.
[31] D. J. Mellett, 'Bureaucracy and mental illness: the Commissioners in Lunacy, 1845-90,' *Medical History*, 1981, p. 225.
[32] *Ibid.*
[33] *Lunacy Act, 1890, 53 Vict., CH5*, pp. 36-37.
[34] *Ibid*, pp. 93-94.

notorious therapeutic measure. In the Act, psychiatric asylums and hospitals were advised not to apply mechanical restraint unless it was necessary for purposes of medical treatment.[35] If being applied, the case was to be reported to the Commissioners at the end of each quarter.[36] As we shall see, however, this regulation was not uniformly applied.

In order that confinements in asylum were not necessarily prolonged, the 1890 Act provided two informal discharge systems. One was called 'absence on trial' in which 'two visitors of an asylum' could 'permit a patient in the asylum to be absent on trial so long as they think fit.' The managers of registered hospitals and private asylums could also send patients to any place for a period as might be 'thought fit for the benefit of his or their health.' Another informal discharge was boarding-out, which enabled patients' relatives to provide their own care for patients before complete discharge.

Restrictions on Private Asylums

As important as legal certification in the 1890 Act was its restriction on the expansion of private asylums. In light of late nineteenth-century scandals, the Act provided a clause that inhibited further licensing to private asylums.[37] Section 207 provided that:

> No new licence shall be granted to any person for the reception of lunatics, and no house in respect of which there is at the passing of this Act an

[35] *Ibid*, p. 38.
[36] *Ibid*, p. 34.
[37] See Section 207 (*Ibid*).

existing licence shall be licensed for a greater number of lunatics than the number authorised by the existing licence.[38]

Through restricting the expansion, the Act was designed to extinguish private asylums gradually.

The indirect restriction enabled the government to avoid compensating institutions for closure.[39] Therefore, the existing licensees were allowed to share the license jointly and to transfer the license to 'the proprietor, or to any other medical manager while employed by the proprietor in the place of the former manager.'[40] The trade in lunacy licences was designed as advantageous for qualified doctors. They could transfer their licenses to the proprietor or to any other medical superintendents of private asylums without intervention of the Lunacy Commissioners.[41] In the other cases, the transfer needed Lunacy Commissioner's sanction.

Because of the restrictive legislation, there was no increase in the number of institutions, admissions and appointments of doctors in private asylums after 1890, which will be shown in Chapter 3. Hence, the private sector went into decline from the late nineteenth century, when the medical market in general expanded significantly.[42] It was time for psychiatrists interested in the private sector to mobilise a counter rhetoric.[43]

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[38] *Ibid*, pp. 103-104.
[39] Charlotte MacKenzie, *op.cit.*, p. 204.
[40] *Lunacy Act, 1890, 53 Vict., CH5*, p. 104.
[41] *Ibid.*
[42] Anne Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911*, Cambridge; New York: Cambridge University Press, 1994.
[43] In 1891, an amendment bill to the 1890 Act was enacted, but contained no special change to the original Act. Its purpose was to remove practical difficulties and misleading expressions found in the actual operation in 1890 (54 & 55 Vict., c.65).

Chapter Two. Constructing 'Early Treatment of Mental Disorder,' 1890-1914

Introduction

Resisting the legalistic approach of the Lunacy Act of 1890, certain elite psychiatrists and physicians initiated a political campaign for alternative legislation. Among them were John Sibbald (1833-1905), William Gowers (1866-1940), Nathan Raw (1866-1940), and Robert Armstrong-Jones (1857-1943). These medical critics insisted that legal certification had an injurious effect on patients, specifically on their prognosis and social status, and advocated a new legislative idea, 'early treatment of mental diseases,' on allegedly humanitarian and therapeutic grounds. By 1914, they had established this argument, but were still unable to enact it.

Other histories of British psychiatry have described this rhetoric in terms of progressive ideological shifts in English psychiatry.[1] However, this dissertation insists that it was constructed significantly through psychiatrists' self-interests in the private sector. In particular, this chapter explores psychiatrists' employment of humanitarianism, physiological aetiology and preventive medicine in politics. In such terms, psychiatrists advertised their self-interests in the name of 'the Magna Charta' of early twentieth-century psychiatry. The self-interests were those of the elite psychiatrists in the private sector psychiatry for wealthy clients. However, by

[1] Louise Westwood, *op.cit.*, 2001, pp. 439-457; D.K. Henderson, *The evolution of psychiatry in Scotland*, Edinburgh: Livingstone, 1964, pp. 108-116; Mathew Thomson, 'Mental hygiene as an international movement,' Paul Weindling (ed.), *International health organisations and movements, 1918-1939*, Cambridge, 1995, p. 283; Nikolas Rose, *op.cit.*, 1985, p. 161.

1914, psychiatrists had failed to achieve amendments to the 1890 Act. Their defeat highlights the political limits of English psychiatry before the Great War.

1. Earlier Criticism Over the 1890 Act, 1890-1901

Robert Percy Smith and Psychiatrists' Resistance to Legalism

The first critic of the 1890 Act was Robert Percy Smith (1853-1941). He was an elite psychiatrist who served as the resident physician of the Bethlem Royal Hospital between 1888 and 1898, succeeding George H. Savage (1842-1921), another eminent psychiatrist.[2] After his work at Bethlem, Percy Smith went into consulting practices at Harley Street in London, where he enjoyed fame and fortune.

In 1891, Percy Smith initiated a criticism of the 1890 Act and its legal certification, focusing in particular on the need for justices who could issue the certification.[3] He cited in argument a young male piano tuner who mentally broke down because of too much theological reading.[4] When the piano tuner's disease was found by his relatives, he was sent to the Bethlem Royal Hospital with an urgency order, but did not recover in seven days. Hence, for further treatment, he needed a reception order. To apply for this order, his mother visited a justice in the long list of specially appointed justices in London, but 'the justice refused to have

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[2] *Lancet*, June 14, 1941, p. 774; *British Medical Journal*, June 21, 1941, p. 948; *Psychiatric Quarterly*, October, 1941, p. 854. He was also the president of the MPA, and of Psychiatrical and Neurological Sections of the Royal Society of Medicine, and an editor of *Brain*.

[3] *British Medical Journal*, July 19, 1890, p. 178; *Journal of Mental Science*, October, 1890, p. 598. On the same ground, Percy Smith also criticised the 1890 Act in the Report of the Royal Bethlem Hospital (Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker and Keir Waddington, *The history of Bethlem*, London: Routledge, 1997, pp. 525-527).

[4] *British Medical Journal*, July 19, 1890, p. 178.

anything to do with it and referred her to the Marylebone Police Court.'[5] The court claimed that it could not deal with the case and gave the list of four names of justices in Marylebone. The police court denied the case, since the 1890 Act did not prescribe them with such a power. With the list, the mother proceeded to call on the justices one after another. Three of the four justices were away, and the fourth refused to sign, recommending that the piano tuner's mother visit a stipendiary magistrate. Finally, a justice in Lambeth signed the order. Considering that seven different authorities were sought in this case, Percy Smith argued that the provision of the 1890 Act caused a severe delay of treatment.[6]

Percy Smith also argued that the 1890 Act increased psychiatrists' non-medical activities. In particular, legal certification made 'statutory works threefold [to] what they were' before the enactment.[7] This view was shared by J. Murray Lindsay, medical superintendent of the County Council Asylum at Derbyshire. He remarked in 1893 that:

> Increased clerical and reporting work to satisfy the requirements of an unnecessarily exacting, complicated, and confusing Act...Asylum medical officers...now to a large extent converted into recording and certifying machines, considerable portion of their time being now frittered away in writing useless reports, singing certificates, and other clerical work, to the exclusion of work attended with more real benefit to the patients in the direction of promoting their cure and amelioration.[8]

Other psychiatrists described how legalism jeopardised psychiatry, which they claimed to be a medical science and public welfare service.

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[5] *Ibid.*
[6] In addition to the case, Percy Smith provided further similar cases in which the 1890 Act did not work properly. In seven cases at the Bethlem Royal Hospital, patients' relatives could not have a reception order, and in seventeen cases, justice's signature was improper (*Ibid*).
[7] *Journal of Mental Science*, January 1891, p. 164.
[8] *Ibid.*, October, 1893, pp. 480-481.

Percy Smith also disputed that patients and their relatives were anxious about judicial intervention and that it was injurious to their social respectability.[9] The anxiety reached its peak when patients met justices. Percy Smith bore witness that:

> The judicial authority may visit the alleged lunatic. In two cases admitted here on urgency orders the patients have been much alarmed at the visit of the Justice to the hospital for the purpose of seeing patients before signing the reception order, one of them thinking that she was to be sentenced to something, and the other that she was to be made a pauper lunatic. In both the bad impression remained for days and added to the patients' misery.[10]

Responding to Percy Smith, 21 psychiatrists sent letters to the *Journal of Mental Science*. Most of them agreed with Percy Smith, yet did not think that new legislation was necessary.[11] However, following on from Percy Smith, psychiatrists gradually developed a political complaint about the 1890 Act.

Henry Rayner and Late Nineteenth-Century Legislative Challenges

The psychiatrist who most formalised Percy Smith's criticism was Henry Rayner (1840-1926), medical superintendent of the London County Council Asylum at Hanwell and lecturer of mental disease at St. Thomas Hospital.[12] Like Percy Smith, Rayner later became a successful consulting psychiatrist in Harley Street.

At the meeting of Psychology Section of the BMA in September 1896, Rayner read a paper entitled 'the certification of insanity in its relation to the

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[9] *Ibid.*, October, 1890, p. 598.
[10] *Ibid.*, January, 1891, pp. 61-62.
[11] Only Frederick Needham, medical superintendent of the Barnwood Hospital for the Insane and the later Lunacy Commissioner in England, recommended Percy Smith to petition the Lord Chancellor to introduce an amendment bill to the 1890 Act (*Ibid.*, p. 194).
[12] *Lancet*, February 27, 1926, p. 466; *Times*, March 03, 1926, p. 18.

medical profession.' In this he launched a new direction for psychiatric legislation based on Percy Smith's argument that legal certification brought delay in treatment.[13] This delay was generated by a prejudice against the legal certification of lunacy, he argued. Because of the infamy, patients' relatives avoided sending patients to psychiatrists for treatment. As a consequence of the avoidance of specialist treatment in the initial stage of the disease, patients 'inevitably' became chronic. Hence, the legal certification led patients toward being lifetime inmates of the total institution.

Not only did the legal certification influence prospective patients, Rayner argued, but it pressured incarcerated patients emotionally. Rayner's evidence was of an increase in suicides of asylum inmates after 1890.[14] Suicidal cases jumped from 2,346 in 1892 to 2,619 in 1895, he claimed, exceeding the population growth. This rapid increase showed how intolerable the legal certification was for patients.

With regard to legal certification, Rayner complained that its numerous administrative works obstructed psychiatrists' medical activities. This was not simply generated from his personal exhaustion with the administrative load of the Lunacy Laws. 'The duty of the medical man is only to give his opinion and advice in regard to the line of treatment to be adopted,' he remarked.[15]

In criticising the legalism of the 1890 Act, Rayner focused on early and mild cases, because they were the most pitiful victims of the legislation. To improve this, he called for new legislation that would allow psychiatrists to provide treatment for curable patients in non-asylum accommodations without legal certification. This

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[13] *British Medical Journal*, September 26, 1896, p. 797. Also see correspondences in *Lancet*, July 10, 1897, pp. 113-114.
[14] *British Medical Journal*, September 26, 1896, p. 798.
[15] *Ibid.*

provision, they expected, would make better access to therapeutic solutions.[16] He made a speech:

> I constantly see cases who are not yet certifiable, or for whom a certification would be an injustice in the present state of the law and popular opinion, when a week or two of treatment in a suitable house or hospital would arrest the disorder. I consider, therefore, that there should be devised some procedure which without entailing certification or any evasion of the law, should permit the treatment of incipient cases of mental disorder for a limited period in suitable homes or reception hospitals.[17]

This was the prototype for 'early treatment of mental disorder.'[18] But it was not entirely new; prior to 1889, some psychiatrists had already insisted on the necessity of such a solution.[19] Rayner's early treatment, however, constituted the heart of the post-1890 psychiatric politics, because he linked it with the criticism of legal certification.[20]

Following Rayner, the MPA began a political campaign for an amendment to the 1890 Act. In its Parliamentary Committee, T. S. Clouston (1840-1915), the superintendent of the Royal Edinburgh Asylum, and David Yellowlees (1836-1921), medical superintendent of the Gartnavel Asylum in Glasgow, supported Rayner's thesis that mental diseases were curable if treated in the earlier stages outside asylums and without legal certification.[21] With their support, the Committee drafted an amendment bill that concentrated on the establishment of a new psychiatric branch in general hospitals and asylums for 'temporary and early cases' without

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[16] *Ibid.*, p. 799.
[17] *Ibid.*, pp. 798-799.
[18] *Journal of Mental Science*, October 1891, pp. 507-508. Rayner remarked that early treatment was insisted originally by an American doctor, John S. Butler who practiced in Connecticut. (*Ibid*).
[19] For example, John Bucknill emphasized the importance of early treatment of mental disorder in 1880 (J. C. Bucknill, *The care of the insane and their legal control*, London: Macmillan, 1880, p. 38).
[20] *Journal of Mental Science*, October, 1891, pp. 507-508.
[21] *Ibid.*, October, 1897, pp. 867-868.

legal certification.[22] It also proposed to allow private asylums and registered hospitals to receive voluntary boarder cases with only one Lunacy Commissioner's consent.[23] Both proposals were designed to improve patient's accessibility to psychiatric treatment, by relaxing the legal restrictions under the 1890 Act.[24] This 1897 direction was followed in bills proposed in 1898, 1899 and 1900.[25] The 1899 bill exceptionally extended the principle, by adding a clause that stated that Section 315 of the 1890 Act should not be applied to cases for proposed early treatment.[26]

With the 1897 bill drafted, the MPA petitioned the Lord Chancellor to arrange its introduction into Parliament.[27] The Lord Chancellor was still Lord Halsbury, but, without his making any opposition, he assisted the psychiatrists' political challenge between 1897 and 1900.[28] However, all four bills were withdrawn at the second reading in the House of Commons after having passed through the House of Lords.

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[22] Section 15 in 60&61 Vict., *Public Bills*, 1897.
[23] Section 12 (*Ibid.*) Also see *British Medical Journal*, April 02, 1898, pp. 903-904; *Ibid.*, May 28, 1898, p. 1398.
[24] 60&61 Vict., *Public Bills*, 1897; *British Medical Journal*, April 30, 1898, pp. 1158-59; *Ibid.*, September 16, 1899, p. 703. In addition to these major proposals, the bill provided clauses in which psychiatrists could open new private institutions for mentally deficient patients, and the doctor who certified a person as a lunatic could not be liable for the certification and its damages in Civil Laws.
[25] 02 Vict., *Public Bills*, 1899.
[26] *Ibid.*
[27] *Minutes of the Parliamentary Committee*, 1906-1923 (Royal College of Psychiatrists Archive); *Journal of Mental Science*, October, 1895, p. 741; *Ibid.*, October, 1896, pp. 872-873; *Ibid.*, October, 1897, pp. 867-868; *Ibid.*, October, 1898, pp. 878-879; *Ibid.*, October, 1899, pp. 827-828.
[28] 60 & 61 Vict., *Public Bills*, 1897. Also see *British Medical Journal*, February 26, 1898, p. 582.

2. Humanisation of Psychiatric Politics, 1902

John Sibbald and the Scottish Campaign for Early Treatment

In 1902, psychiatrists further developed their political claim for the early treatment of mental disorder, by incorporating into it the rhetoric of humanitarianism. This development was initiated by John Sibbald, an eminent Scottish alienist who had worked in the Royal Edinburgh Asylum and the Argyle and Bute Asylum for thirty years. He had also been Lunacy Commissioner in Scotland until 1899.[29]

In February 1902, Sibbald submitted an important paper to the special meeting of the Edinburgh Medico-Chirurgical Society: 'The treatment of incipient mental disorder and its clinical teaching in the wards of general hospitals.'[30] In this, he identified legal intervention as 'an important defect' in the treatment of mental diseases, and suggested the establishment of a special ward at the Royal Edinburgh Infirmary for 'treatment of incipient and transitory mental disorder.'[31] This became knew generally as the 'Edinburgh Scheme.'[32]

The Edinburgh Scheme shared the same measure as English psychiatrists had proposed for early treatment of mental diseases in the 1890s: for instance, the establishment of a psychiatric branch in general hospitals. Scotland, though, differed from England in terms of legislation. In Scotland, the Lunatics Act of 1857 required an order of the sheriff and two medical certificates in its admission

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[29] *Lancet*, May 6, 1905, pp. 1019-1020; *Ibid.*, May 13, 1905, p. 1304. Sibbald was known as an 'innovator' of the Scottish mental health services in the latter part of the nineteenth century. His biographies record that he paid constant attention to 'humanising and modernising asylums,' introducing trends in continental psychiatry to British psychiatrists (*Ibid*; *Ibid.*, March 4, 1899, pp. 622-623.). For example, he authored a book on the Gheel Colony for the Insane in Belgium which was famous for its non-asylum care of the insane provided by local host families (*British Medical Journal*, May 6, 1905, pp. 1019-1020; *Lancet*, May 13, 1905, p. 1304.)

[30] *Journal of Mental Science*, April 1902, pp. 215-226.

[31] *Ibid.*

[32] *Ibid.*

procedure, but did not impose any restrictions on the treatment of voluntary cases and private practices.[33] By taking the same measure for early treatment, Sibbald expected to remedy a common problem of the legal intervention in psychiatry. Hence, his stress was similarly upon how harmful the legal intervention was to psychiatric patients. Sibbald said:

> The legislature has judges it necessary so to hedge round with statutory precautions the admission of patients to these institutions [asylums], and there are such impediments in the way of their admission, due to social considerations, that it is not until mental disorder has taken indubitable hold of a patient, and not even then in many cases, that the asylum can be resorted to. The statutory precautions prevent the admission to an asylum in Scotland of every person for whom medical certificates, according to a prescribed form, and a sheriff's order cannot be obtained.[34]

In psychiatrists' representations, legal intervention was an issue of social respectability.

To English psychiatrists, the Edinburgh Scheme seemed a model for their legislative challenge. When Sibbald's paper was presented again at the meeting of the BMA in October, they spoke highly of Sibbald's challenge, since it would be a good reference in their attempt for new legislation.[35]

Not only did Scottish psychiatrists provide a model, they invented a new way to justify the early treatment of mental diseases - humanitarianism. Receiving Sibbald's paper, they concentrated on the issue that legal certification brought social disapproval on to patients. Scottish psychiatrists described it fixedly as the 'stigma of legal certification.'[36] At the Edinburgh meeting, Alexander Bruce (1855-1911),

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[33] Clive Unsworth, *op.cit.*, pp.86-87. Also see Harriet Sturdy and William Perry-Jones, 'Boarding-out insane patients: the significance of the Scottish system, 1857-1913,' Peter Bartlett and David Wright (eds), *op.cit.*, 1999, pp. 86-114.
[34] *Journal of Mental Science*, April 1902, p. 218.
[35] For example, *Transactions of the Medico-Legal Society*, 1914, pp. 28-29; p. 43.
[36] *Journal of Mental Science*, April, 1902, pp. 215-218.

physician to the Royal Edinburgh Infirmary, set the issue of 'the stigma of having been in an asylum' as 'one of the strongest arguments for the proposed change.'[37] At the BMA meeting, David Yellowlees described legal certification as 'unjust stigma' cast upon asylum inmates.[38]

This term impressed medical critics in general. They employed it to criticise the 1890 Act. Referring to the Edinburgh scheme, a Scottish correspondent of *The Lancet* remarked that 'acute insanity of a temporary nature could be successfully treated in the special wards of a general hospital without the stigma which was attached to even a short residence in an asylum as a certified lunatic.'[39] Later, this correspondent again stressed that the object of the establishment of psychiatric wards was 'to avoid the stigma attached to a person who is sent to an asylum.'[40]

Not only Scottish doctors, but their English counterparts began attacking on the stigma of legal certification. At the BMA meeting, Alfred Taylor Schofield (1846-1929), a Harley Street physician, agreed with Sibbald on the necessity 'to remove the indelible stigma that must attach to all asylums where a patient was definitely marked as "insane."'[41] Other medical and psychiatric respondents were also of the opinion that the current legislation degraded the social status of mentally ill patients.[42] A *Lancet* editorial of 1902 commented that 'it is quite true that, rightly or wrongly, the public does view with dislike and distrust the placing of persons in special institutions under certificates, putting the "stigma of insanity" upon them, as it is termed.'[43] The stigma of legal certification became a symbolic phrase to argue

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[37] *Ibid.*, p. 382.
[38] *British Medical Journal*, October 18, 1902, pp. 1204-06.
[39] *Ibid.*, January 25, 1902, p. 265.
[40] *Ibid.*, March 1, 1902, p. 622.
[41] *Ibid.*, October 18, 1902, p. 1205.
[42] *Ibid.*
[43] *Lancet*, February 1, 1902, p. 318.

about the malfunction of the 1890 Act, and constituted the humanitarian grounds for justifying early treatment of mental disorder.[44]

William Gowers and Radical Psychiatric Humanitarianism

In 1902, William Gowers, the physician and professor of clinical medicine of the University College Hospital, and physician to the National Hospital for the Paralysed and Epileptic at Queens Square, evolved a humanitarian objection to legal certification.[45] He was a physician well-known for his neurological works, such as *Manual of diseases of the nervous system*, in Anglo-American and continental medicine. His neurological works connected him to psychiatry.

In November 1902, Gowers disputed 'Lunacy and the Law' at the meeting of the MPA.[46] In this he documented how legal certification had an inhumane influence on patients.[47] Under the 1890 Act that required legal certification in most admissions, he complained, recoverable classes of patients were compelled to go into 'the same course, the same stigma, the same distressing processes' as incurable and pauper cases.[48] This down-spiral started with legal certification of lunacy, and went through to compulsory detention at an asylum – the social institution where it was difficult for patients to get out of. Even if patients could get out, their usual life

[44] *Ibid.*, December 8, 1894, p. 1368; *Ibid.*, October 13, 1894, p. 856; *Ibid.*, March 4, 1899, pp. 604-605; *Ibid.*, May 11, 1901, pp. 1319-1322.
[45] G.H. Brown (ed.), *Lives of the fellows of the Royal College of Physicians of London, London: Royal College of Physicians*, 1955, p. 264; *Oxford DNB*; *Times*, May 5, 1915, p. 7; Macdonald Critchley, *Sir William Gowers, 1845-1915*, London, 1949.
[46] *Journal of Mental Science*, January, 1903, pp. 189-190. Also see *Lancet*, November 22, 1902, pp. 1369-1373.
[47] *Journal of Mental Science*, January, 1903, p. 189.
[48] *Lancet*, November 22, 1902, p. 1369.

and work was never fully restored, because they were branded legally insane, Gowers concluded.

To remedy this, Gowers deliberately broke Section 315 of the 1890 Act which prohibited any doctor from receiving psychiatric patients without legal certification.[49] Gowers remarked that:

> I arranged a course which was clearly contrary to the law. I sent the patient with his wife to a medical man who received them into his house for payment. What was the result of thus breaking the law? In a fortnight he was well; the delusion was gone. ... In this case...it [certification] would have been purely harmful; it might have destroyed the prospect of recovery and certainly would have delayed improvement.[50]

He also affirmed that with the intent of the patients' cure, he would not hesitate to offend the law.[51] It was on the humanitarian basis that Gowers insisted on the necessity of the early treatment of mental diseases.[52]

Only a few doctors accused Gowers of flaunting the Lunacy Act. Most audiences and medical commentaries sympathized with him and attacked 'the stigma' of legal certification.[53] William Broadbent (1865-1946), the Physician in Ordinary to the Queen, for instance, remarked that Gowers:

> has...struck the true key-note of what should be certified unless it be either for his own advantage, or in the interests of the public, or for the safety of the public. When we remember what it is to be certified - that it is practically a sentence of imprisonment much more severe than our worst criminals are exposed to...I believe it will be seen that their punishment and their sufferings are worse than those of the habitual criminal when he is sent to prison...when we remember that the fact of any member of a family being sent to asylum brings a stigma upon the individual, and that even if he gets well his self-respect is wounded for ever, that he can never lift up his head

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[49] *Ibid.*, p. 1370.
[50] *Ibid.*
[51] *Ibid.*, p.1369.
[52] *Journal of Mental Science*, January, 1903, p.190.
[53] *Ibid.*, pp.195-202; *Lancet*, November 29, 1902, p. 1487; *Ibid*, January 31, 1903, pp. 331-332.

> again in society, and that the family is injured in perpetuity, you will see the force of what I say. This question should be tested from the view of the public, and you may depend upon it I am stating what does not go beyond the truth.[54]

Psychiatric doctors responded to Gowers with sympathy, and stressed the humanitarian importance of avoiding the stigma of legal certification. Thomas Claye Shaw (1846-1927), a Harley Street consulting physician specialising in the treatment of mental diseases, remarked that 'the friends of patients would doubtless welcome the introduction of any measure which would save the family name from the fancied stigma of certificates.'[55] Referring to the Edinburgh Scheme, John Batty Tuke (1835-1913), late physician to the Edinburgh Royal Infirmary and a Member of Parliament, stressed the humanitarian advantage of the Scottish legislation over the English one. He remarked that 'a large proportion of incipient and mild cases are cured by treatment at home and under the six-months' certificate, and, of course, never bear after recovery anything like what is generally considered the stigma of lunacy.'[56]

The few doctors who objected to Gowers were concerned about the legitimacy of asylum treatment, not about Gower's illegal conduct. Alexander Reid Urquhart (1852-1917), physician to the James Murray's Royal Asylum at Perth, remarked that:

> I lately treated a patient in one of our detached houses. She declared, "I shall never be well until you take me into the asylum." She went from bad to worse until she had to be brought into the asylum, where she rapidly recovered. This was done at the expense of the stigma of the lunatic asylum. We hear a great deal too much about stigmata, and one becomes rather impatient of the iteration.[57]

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[54] *Journal of Mental Science*, January, 1903, p.195.
[55] *Lancet*, January 31, 1903, p. 332.
[56] *Journal of Mental Science*, January, 1903, p.197.
[57] *Ibid.*, p.202.

Thomas Outterson Wood (1843-1930), an eminent psychiatric consultant in London and the senior physician to the West End Hospital for Nervous Diseases, differently approached Gower's paper. He denied Gowers' argument, saying that 'feeling a stigma of lunacy was a mere sentiment. Nothing could alter the fact that the patients were insane.'[58] However, no psychiatrist followed him; most seemed to have been impressed by Gowers's heroic action.

'Stigma' was a popular term initially in poor law reform around the turn of the twentieth century. Deterrent welfare legislation, it was argued, degraded it recipients, leading them into a distress from which they could never escape.[59] This view was widely accepted. The psychiatrists' use of it was intended to change the public impression of the 1890 lunacy legislation - from the one that prevented the psychiatrists' trade in lunacy to one that supported medical science and public welfare. Gowers and other psychiatric critics pursued 'stigma' to fan popular sentiment against the legal certification embedded in the 1890 Act. This was political humanitarianism.

3. Politicisation of Scientific Knowledge: Nathan Raw's Aetiology for Early Treatment, 1904

Not only did humanitarianism serve for psychiatric politics, but it also served psychiatric aetiology in constructing the notion of the benefits of early treatment of mental disorder. This was articulated by Nathan Raw, medical superintendent of the

[58] *Lancet*, February 14, 1903, pp. 427-430; *Ibid.*, p. 577.
[59] Paul Spicker, *Stigma and Social Welfare*, Croom Helm: St. Martin, 1984.

Mill Road Infirmary in Liverpool.[60] He was regarded generally as a 'progressive' physician who contributed to the reorganization of voluntary and poor law medicine. A specialist in the care and aetiology of tuberculosis, he was also interested in the relationship between mental and bodily disease.[61] A member of the MPA, he also served as the president and chairman of its Parliamentary Committee in the 1920s. Between 1918 and 1922, he was Member of Parliament for the Wavertree Division of Liverpool.

In 1904, Raw delivered a paper at the meeting of the MPA in which he argued for the early treatment of mental disorder on aetiological grounds.[62] Maintaining that 'mental symptoms are common in the other diseases,'[63] he criticised the 1890 legislation for unnecessarily branding patients suffering from temporary and bodily-oriented mental disease with the social stigma of lunacy.[64] Raw explained that mental diseases in most cases developed in the course of pneumonia, typhoid fever, or toxic poisoning by alcohol, belladonna, or in the course of septic infection, such as puerperal septicaemia, bodily diseases whose symptoms were transient. In doing so, he stressed the acute and temporary nature of much mental illness, and questioned whether it was necessary for a patient, whose disease originated from a physical cause, to bear the stigma of legal certification of lunacy. His answer was negative:

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[60] Regarding Raw's biographical information, see *Lancet*, September 14, 1940, pp. 346-347; *British Medical Journal*, September 14, 1940, p. 368. Also see Roger Cooter, 'The rise and decline of the medical member: doctors and Parliament in Edwardian and interwar Britain,' *Bulletin of the History of Medicine*, Vol. 78, 2004, p. 76; M. Stenton, S. Lees (eds), *Who's who of British Parliamentary Members of Parliament*, Vol. 3, 1919-1945, Sussex, 1979, p. 296.
[61] John V. Pickstone, *Medicine and industrial society: a history of hospital development in Manchester and its region, 1752-1946*, Manchester University Press, 1985, p. 224.
[62] *Journal of Mental Science*, January, 1904, pp. 13-22.
[63] *Ibid.*, pp. 21-22.
[64] *Ibid.*, p. 13.

> A very large number of people are sent to asylums who, if accommodated in some temporary mental hospital, would quickly recover, and thus be spared the stigma of having been certified as insane. ... I know from intimate acquaintance that this stigma is real and not sentimental, and it is a fact that a workman or other employee who has been an inmate of an asylum has great difficulty in obtaining employment if the fact is known to the employer.[65]

To justify his thesis, Raw cited the example of a tradesman in Liverpool who had depression owing to some bereavement or financial difficulty.[66] This difficult situation compelled the person to be sent to a poor-law infirmary as a pauper. At the infirmary he was certified as a lunatic, even though his disease was mild and temporary, Raw insisted. This was directly because he had no specialist treatment and advice at the place, but also indirectly because the 1890 Act provided no medical facility for early cases of mental diseases. Describing the fate of such a patient as unnecessarily cursed by inhumane legalism, Raw argued that such patients should be saved from the stigma of certification. The way to rescue them was through the early treatment of his mental disorder.

Raw's view was not new; other psychiatrists had similarly emphasised a common nature between mental disease and physical disease.[67] In 1903, for instance, Robert Armstrong-Jones, medical superintendent of the London County Council Asylum at Claybury, argued that insanity was:

> nothing more or less than a disturbance of mind involving a disturbance of conduct - the former a sign and the latter a symptom of disturbed nerve processes. With every mental change it is probably without exception that some change occurs in the central nervous system. There is thus no mental

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[65] *Ibid,*, January, 1904, p. 14; pp. 24-28.
[66] *Ibid.*, pp. 13-14.
[67] William F. Bynum, 'The nervous patient in 18th- and 19th-century Britain: the psychiatric origins of British neurology,' *Lectures on the history of psychiatry : the Squibb series*, London: Gaskell, 1990, pp. 115-127; Michael J. Clark, 'The rejection of psychological approaches to mental disorder in late nineteenth-century British psychiatry,' Andrew Scull (ed.) *Madhouses, mad-doctors, and madmen : the social history of psychiatry in the Victorian era*, London: Athlone Press, 1981, pp. 271-312.

state without its corresponding nervous state - "No psychosis without neurosis."[68]

A particular difference between Raw and Armstrong-Jones was that Raw's aetiology was politically linked with psychiatrists' campaign against the 1890 Act; the theory provided scientific legitimacy for the early treatment of mental disorder.[69]

Raw's paper stimulated the MPA to petition the government for new legislation. Directly as a result, the Attorney-General introduced an amendment bill to the 1890 Act in the House of Commons.[70] Its major provision was the same as the 1900 bill - treatment of mild mental cases at general hospitals without legal certification.[71] To relax the 1890 legislation, however, it was added a clause that allowed mild and curable cases of mental disease to be treated 'under the care of a

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[68] *Lancet*, June 6, 1903, p. 1572.

[69] *Ibid.*, October 18, 1924, pp. 789-792. The political nature of Raw's aetiology of mental diseases is observable in the fact that while talking about early treatment, he never referred to heredity in explaining psychiatric aetiology, although it was common in early twentieth-century psychiatric theories whereby psychiatrists often remarked that the first cause of insanity was heredity (*Lancet*, October 26, 1911, pp. 1-30; *Ibid.*, January 28 1913, p. 23). In 1911, the annual report of the Commissioners in Lunacy recorded that 29.5 per cent of the male pauper patients, and 35.3 per cent of the female pauper patients were hereditary insane (*Annual Report of the Commissioners in Lunacy*, 1911, p. 19). In 1908, William Gowers also remarked that among 1,193 males suffering from insanity and epilepsy, 39 per cent was hereditary. The female hereditary insane was 42 percent, 519 of 1,207 (*Proceedings of the Royal Society of Medicine*, November 11, 1908, pp. 20-21). Despite this trend, when referring to early treatment, not only Raw but also most psychiatrists avoided the hereditary explanation of insanity. This seems deliberate because the hereditarian aetiology would stress the incurable and chronic nature of insanity rather than its curable and acute nature. It would also invalidate their claim that mental disease was curable if treated in the early stages. This view is supported by the statement of Bedford Pierce (1861-1932), medical superintendent of the York Retreat, that insanity would usually cast the 'stigma upon a family through disclosure of hereditary weakness' (*British Medical Journal*, January 8, 1916, p. 43)' and by the *Lancet*'s one that indicated the class difference in relation to early treatment of mental disorder: 'It seems hopeless to expect that in the lower classes the stigma of having been treated in an asylum will ever be eradicated, because employers of labour are very suspicious of having in their midst anyone who is known to have been at any time placed in such conditions, and thus it comes about that the stigma of insanity means starvation; the better classes are, or should be, too well informed to be ignorant of the fact that heredity taint is very wrongly interpreted in the majority of cases, and that any attempt to elude the law [the 1890 Act] drawn up for the protection of persons in public or private retreats is sure to result in a form of seclusion which may be all the worse because it is secretly enforced' (*Lancet*, April 5, 1902, p. 976). This evidence reminds us that 'the better classes' were important clients of elite psychiatrists, the political leaders of the profession. From this perspective, the early treatment of mental diseases was possibly political and self-interested, even if it was seemingly concerned with scientific theories.

[70] *Journal of House of Commons*, Vol. 159, 1904.

[71] 4 EDW 78., *Public Bills*, 1904.

person whose name and address are stated in the certificate for a period therein stated, not exceeding six months.'[72] This clause virtually established private provision that was free from legalism, since it enabled any person, whether laymen or qualified doctors, to provide treatment for mental patients without legal certification.

The 1904 bill was withdrawn after its introduction in the Commons.[73] Frustrated, psychiatrists were forced to suspend their political campaign.[74] In 1909, an editor of the *Journal of Mental Science* remarked that:

> The prospect of lunacy legislation in the present is hopeless, but the deferred hope should not have the saddening effect on this association which is usually supposed to result from such an emotional state. ... Many of the legislative reforms needed for the care of the insane have been already endorsed by a Royal Commission, so that the neglect to carry them out is a direct affront to the Crown, by whose authority such Commissions are appointed.[75]

No Royal Commission was appointed until 1924, however.

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[72] *Ibid.*
[73] *Journal of House of Commons*, Vol. 159, 1904.
[74] No amendment bill to the 1890 Act was introduced to the Parliament between 1905 and 1913. The major works of the parliamentary committee of the MPA was to consider asylum officers' pension and nursing registration (Royal College of Psychiatrists Archive, *Minutes of the Parliamentary Committee*, 1906-1923). Also see F.R. Adams, 'From association to union: professional organisation of asylum attendants, 1869-1919,' *The British Journal of Sociology*, Vol. 20, pp. 11-26.
[75] *Journal of Mental Science*, October 1909, p. 523.

4. Politics of Preventive Psychiatry, 1913-1914

Robert Armstrong-Jones and Rhetorical Politics of Psychiatry

The psychiatrist who reinvigorated the profession's political campaign was Robert Armstrong-Jones, medical superintendent of the London Country Council Asylum of Claybury from 1893 to 1916.[76] A public asylum doctor, he was famous for his superintendence at the Claybury Asylum, the most progressive institution in England. It had a pathological laboratory whose director was Frederick Walker Mott (1853-1926), an established neuropathologist. As a spokesman for the institution, Armstrong-Jones published numerous articles in medical journals and popular circulations and gained professional and popular acknowledgement.

From late 1913, Armstrong-Jones revived the political campaign for the early treatment of mental disorder, connecting Raw's political aetiology with psychiatric humanitarianism, and adding another rhetorical ground for preventive medicine. His political performance was initiated at a meeting of the Medico-Legal Society, where the medical and legal professions discussed matters between medicine and law.[77] Reading a paper entitled 'The rational treatment of incipient insanity and the urgent need for legislation,' he argued, as Gowers had, that the 1890 legislation victimised mentally ill patients. Madness, Armstrong-Jones claimed, was simply a disease, but outside medicine, it meant compulsory detention at lunatic institutions with legal formalities, because of the 1890 Act.[78] Thus mental patients were led to extremes of despair. For instance, puerperal insanity was generally caused by a temporary

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[76] *British Medical Journal*, February 6, 1943, p. 175; *Oxford DNB*; G.H. Brown, *op.cit.*, 1955, pp. 480-481.
[77] *Transactions of the Medico-Legal Society*, Vol. 1, 1902. The Medico-Legal Society was established by the legal professionals in 1901.
[78] *Ibid.*, Vol. 8, 1914, p. 24.

physical ailment in childbirth such as 'a slight fissure of the cervix uteri.' This female problem was no more than a disease in medicine. However, because of the legalistic legislation, a mother who had puerperal insanity feared 'the stigma of lunatic asylum, which will not only stamp her as an outcast among her family, but will also cast a permanent blemish upon her children, and their future chances in life will also be prejudiced.'[79] For such patients, the 1890 Act provided no alternative but to be legally certified as a lunatic. General hospitals could not admit these cases. Such patients, deterred by the legal stigma from accessing specialist treatment, were doomed to a chronic fate.

It was seen more disgraceful if the mother was from a poor family. Armstrong-Jones wondered how a poor mother with a mental problem was forced to bring up children, look after elderly members, and stay up at 'night nursing her sick child in an overcrowded room - often the only one - with bad air, worse food, with noise and worry.' She would definitely end up in a poor-law infirmary and be confined in an asylum.[80]

Citing the misery of puerperal insanity, Armstrong-Jones argued that 'it is cruel that these rescuable cases and their families should not get a chance of being saved the reproach of a painful as well as of a permanent stigma.'[81] Early treatment of mental disorder was therefore something more than a Christian duty, if not almost a 'right.' He argued that if early treatment was allowed legally, 'the stigmatisation of the mother would be prevented,' and she could live a sound and useful life as a

[79] *Ibid.*, pp. 25-26.
[80] *Ibid.*, p. 25.
[81] *Ibid.*, pp. 25-26.

'guardian of the family and mother of her children.'[82] The story was clear - the 1890 Act was unreasonable and mothers were its victims.[83]

Based on the paper delivered at the Medico-Legal Society, Armstrong-Jones developed his heroic performance, and it reached its peak in July 1914. He wrote:

> The whole object of the bill [amendment bill to the 1890 Act] was to avoid stigma of certification, and the bill would make it possible for rich and poor to be treated outside the gates of an asylum; the potentially insane would be saved from the damning certificate.[84]

The amendment of the 1890 Act meant, in his mind, entirely humanitarian relief.

He also criticised the legislation on the rhetorical basis of preventive medicine. As mentioned in the above case of puerperal insanity, legal certification deterred potential patients and their families from accessing a psychiatrist's treatment, and this resulted in an increase in chronic patients. Developing this causation, he argued that the increase of chronic patients would be a burden on the public finances.[85] The solution was the early treatment of mental disorder. If treated in its early stages, mental disease was most successful in results, and this fact was 'of immense importance to the community, both from the point of view of prevention as well as finance.'[86] He continuously laid emphasis on this point:

> What we urgently need, not only for the sake of patient, not only for the sake of his relatives, but for the sake of humanity, and for the sake of true economy, is greater elasticity to treat the early symptoms of this disease, to treat them during the stages when an accurate diagnosis may not yet be possible, and before the disease has become chronic.[87]

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[82] *Ibid.*
[83] *Ibid.*, p. 25.
[84] *Lancet*, July 4, 1914, p. 36; *British Medical Journal*, July 4, 1914, p. 27.
[85] Also see London County Council Minutes of Proceedings, 1902, p. 1551 (London Metropolitan Archives). This shows that as Armstrong-Jones said, the London Country Council was concerned about preventive measures in psychiatry in terms of finance.
[86] *Transactions of Medico-Legal Society*, 1914, p. 22.
[87] *Ibid.*, p. 32.

The idea of the early treatment of mental disorder thus became a matter of economy, humanity and preventive medicine.

The psychiatric and medical press delighted in Armstrong-Jones' intervention.[88] A *Lancet* editorial proposed abolishing legal certification that attached 'the stigma of lunacy' to patients.[89] Only a few non-psychiatric critics expressed doubts. Roland Burrows (1882-1952), a barrister and the late Recorder of Cambridge, suspicious of psychiatric humanitarianism, remarked that 'psychiatrists deserved criticism because they had not agreed amongst themselves what were the standards of sanity and insanity.'[90] C. Woodward (1881-1957), surgeon to the Hampstead General Hospital and North West London Hospital, said that 'puerperal insanity was a bad case to take for purposes of the bill; such patients were absolutely insane at the moment.'[91] But, these remarks were lost in the deluge of cheers for Armstrong-Jones from his professional colleagues.

The Medico-Legal Society consequently drafted an amendment bill for new lunacy legislation, which was promoted both by psychiatrists and medical journals.[92] Armstrong-Jones himself sent a letter to *The Times* in which he stressed the humanitarian importance of the new legislation.[93] But the public press backfired on him. He was criticised for proclaiming the 1914 bill amending bill as 'the Magna Charta of every person likely to suffer from nervous stress and breakdown,' and that '80 per cent of the population should be certified,' if the bill was not enacted[94]

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[88] *Ibid.*, p. 36; pp. 42-45; pp. 56-58. Henry Rayner and Nathan Raw also joined the discussion, agreeing with Armstrong-Jones (*Ibid.*, pp. 52-56).
[89] *Lancet*, February 7, 1914, pp. 397-398.
[90] *British Medical Journal*, July 4, 1914, p. 27. Regarding Sir Roland Barrows, see *Times*, June 16, 1952, p. 8.
[91] *British Medical Journal,* July 4, 1914 , p. 27.
[92] *Ibid.*
[93] *Times*, June 15, 1914, p. 9.
[94] *British Medical Journal*, July 4, 1914, p. 27.

Earl Russell and the 1914 Bill

In 1914, the psychiatrists were joined by a politician, the third Earl Russell, John Francis Stanley Russell (1865-1931). A grandson of Lord John Russell, Prime Minister twice between the 1840s and 1860s, he was the elder brother of Bertrand Russell.[95] His political credentials were less distinguished, however, having dismissed from Oxford and purged from the House of Lords for bigamy in the 1900s.[96] In July 1914, Earl Russell introduced the Voluntary Mental Treatment Bill in the House of Lords.[97] It aimed to allow psychiatrists to deal with mental disease at its early stage without legal certification, and to abolish Section 315, the penalty clause for treatment without the certification.[98] Russell ardently advocated the cases, reiterating Armstrong-Jones' contention that mental disease was often curable if caught early, but, sadly, patients were sent to asylums 'with stigma of insanity' under the 1890 legislation. He insisted on the necessity for safeguarding such patients from the 'exceptional hardships' inflicted legally.[99] He also emphasised the preventive value in the early treatment: the aim of the 1914 bill, he said, was to prevent persons, whose mental condition was uncertain but required medical treatment, from becoming chronic lunatics.[100]

> There is a great growth apparently of lunacy. I say "apparently," because some critics think that the growth is partly due to more cases being certified.

[95] *Times*, March 05, 1931, p. 9; *Ibid.*, March 10, 1931, p. 19. As for Earl Russell's biographical information, also see *Transactions of Medico-Legal Society*, 1931, p. 100; Nicolas Griffin (ed.), *The selected letters of Bertrand Russell*, Vol. 1-2, 1992-2001. In the House of Lords, he was a unique member; he was the first Lord who belonged to Labour, though he was not treated well. For he was not able to become a ministerial member in the first Labour government. Regardless of his pedigree, he was forced to be isolated from the mainstream of politics.
[96] Russell insisted that he had obtained divorce in America in 1899.
[97] *Lancet*, 8 August, 1914, pp. 428-429.
[98] HL/PO/JO/10/10/561 (Parliamentary Archives, 1914).
[99] *Ibid.*
[100] *Ibid.*

> I think it is the opinion of practically all medical men that there are a great many cases in which symptoms of mental instability, if treated [in the] early stage by proper supervision and care, might never develop into certifiable insanity. Of course, every one of your Lordship would agree that if such treatment could be given, and if it should achieve the results of curing a lunatic, if I may put it so, before the person becomes a lunatic, and prevent the person from being under the stigma of having been certified a lunatic, and also save the consequent expense, it would be a very desirable result.[101]

This rhetorical choice was virtually the same as the psychiatrists had contended between 1902 and 1914. But, despite or perhaps because of Russell's help, the 1914 bill was withdrawn just after the first reading in the House of Lords.[102] With the outbreak the war, the bill did not even appear in the *Public Bills*, as a parliamentary paper.

5. The Political Limit of English Psychiatry, 1897-1914

From 1890 to the eve of the Great War, psychiatrists continuously failed to establish early treatment of mental disorder. But try they did, with some six amendment bills introduced to Parliament between 1897 and 1914.[103] Between 1897 and 1900, four bills passed through the House of Lords without serious objections,[104] but all of them were withdrawn in the Commons during, or before, their second reading. The Commons little discussed these bills.[105]

The parliamentary failure was disappointing to English psychiatrists, since they had political support from medical organisations and the government. The

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[101] *Parliamentary Debates: House of Lords*, Vol. 17, 1914, p. 89.
[102] *Journal of the House of Lords*, Vol. 97, 1914.
[103] *Ibid.*, Vol. 79-97, 1897-1914; *Journal of House of Commons*, Vol. 152-169, 1897-1914. Also see Vict., *Public Bills*, 1897; 02 Vict., *Public Bills*, 1899; 4 EDW 78., *Public Bills*, 1904; HL/PO/JO/10/10/561(Parliamentary Archives, 1914).
[104] *Journal of the House of Lords*, Vol. 79-83, 1897-1900.
[105] *Journal of House of Commons*, Vol. 152-155, 1897-1900.

Lord Chancellor and the Attorney-General cooperated in the introduction of the parliamentary bills between 1897 and 1904,[106] and between 1899 and 1900, the MPA formed a joint committee with the BMA for the amendment of the 1890 Act. There were also successful meetings with deputations to the Lord Chancellor.[107]

Psychiatrists perceived their lack of success as caused simply by 'want of time' and 'pressure of business' in Parliament.[108] There were several causes. The 1890 Act was never a major matter of party politics. No party even referred to the subject in their *Year Book*.[109] Indeed, several leading members of the Commons, such as Sir Henry Fowler (1830-1911) and A. J. Balfour (1848-1930), insisted that the House should avoid 'contentious' bills like amendment bills to the 1890 Act.[110] In 1900, when Edward Hare Pickersgill (1850-1911) asked parliamentary members to proceed with the amendment bill to the 1890 Act, John Dillion (1851-1927), the leader of the Irish National Party, responded by denying the importance of lunacy administration.[111] Branded as 'contentious,' psychiatry was lost to the order of parliamentary business and party politics.

The label of 'contentious' was not given groundlessly; private asylums still scandalised the public with tales of the continuing trade of lunacy. In 1900, Charles

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[106] *Journal of the House of Lords*, Vol. 79-83, 1897-1900; *Journal of House of Commons*, Vol. 159, 1904.
[107] *Minutes of the Parliamentary Committee of the Medico-Psychological Association*, 1906-1923 (Royal College of Psychiatrists Archive); *Journal of Mental Science*, October, 1895, p. 741; *Ibid.*, October, 1896, pp. 872-873; *Ibid.*, October, 1897, pp. 867-868; *Ibid.*, October, 1898, pp. 878-879; *Ibid.*, October, 1899, pp. 827-828; *British Medical Journal*, April 15, 1899, pp. 921-922. The joint committee was also established in 1903, but in 1908, the BMA rejected to act with the MPA for amendment to the 1890 Act (*Minutes of the Parliamentary Committee of the Medico-Psychological Association*, 1908).
[108] *Journal of Mental Science*, October, 1904, p. 523; *Transactions of the Medico-Legal Society*, 1914, p. 42.
[109] Iain Dale (ed.), *Liberal Party: General election manifestos, 1900-97*, Routledge, 2000; Iain Dale (ed.), *Labour Party: General election manifestos, 1900-97*, Routledge, 2000; Iain Dale (ed.), *Conservative Party: General election manifestos, 1900-97*, Routledge, 2000; *The Labour Annual*, 1896-1900, *The Liberal Year Book*, 1905; *The Constitutional Year Book*, 1897-1904.
[110] *Parliamentary Debates, House of Commons*, Vol. 51, 1897, p. 1373; *Ibid.*, Vol. 73, 1899, p. 455; *Ibid.*, Vol. 139, 1904, pp. 281-282; *Ibid.*, p. 1084.
[111] *Ibid.*, Vol. 86, 1900, pp. 98-99.

Arthur Russell (1832-1900), the Lord Russell of Killowen, reported a scandal in which several proprietors of metropolitan private asylums bribed the medical officer and the relieving officer of the St. Pancras Parish into bringing mentally ill patients to them.[112] Not only did Russell criticise psychiatry as corrupted, but the *Justice of the Peace*, a weekly law journal, charged that 'this system [bribery] had prevailed elsewhere in the metropolis.'[113] Because of this public mistrust, psychiatrists had few political champions. At the meeting between the MPA, BMA and the Lord Chancellor in 1899, Lord Halsbury suspected that new legislation would invalidate the legal protection from wrongful confinement, whereas he accepted psychiatrists' explanation of the early treatment of mental disorder.[114] Such an ambivalent attitude was also observed in 1904, when the Attorney-General Sir Robert Finlay (1842-1929) introduced a lunacy amendment bill.[115] Overall, the medical profession was underrepresented in Parliament. Doctors, as Cooter pointed out, could ill-afford to suspend their practices in order to enter politics.[116] They were client-dependent rather than colleague-dependent. Psychiatry as a Cinderella branch of medicine was thus in a very weak position, and between 1890 and 1914, the Magna Charta of psychiatry thus stood little chance. It may be partly why the MPA did not even choose to have a parliamentary agent, and why psychiatrists concentrated more on such politically popular ideologies as preventive medicine and public health afterwards.[117] In this line, the political economy of English psychiatry was possibly intermingled with its intellectual side of the history.

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[112] *Ibid.*, Vol. 84, 1900, pp. 1059-1066; *Times*, February 15, 1901, p. 10.
[113] *Justice of the Peace*, July 28, 1900, p. 476.
[114] *British Medical Journal*, March 11, 1899, pp. 625-626.
[115] *Parliamentary Debates: House of Commons*, Vol. 135, 1904, p. 186.
[116] Roger Cooter, *op.cit.*, 2004.
[117] In 1928, the MPA withdrew its proposal for appointing a parliamentary agent because of the 'high cost' (*Minutes of the Parliamentary Committee of the Medico-Psychological Association*, 1928).

Conclusion

Throughout, this chapter has argued that, facing a professional economic crisis caused by the Lunacy Act of 1890, the psychiatric profession constructed a political claim - the early treatment of mental disorder - as a new justice for the public. In doing so, it reconsiders an importance of the economic factor in making early twentieth-century psychiatric politics, as well as ideological factors. The economic demands were not materialised in actual politics between 1890 and 1914. It was in the Great War that British legislators realised that legal stigmatisation of the mentally ill was an important issue.

But before we turn to this, we need to look at two practical measures implemented in the political rhetoric for the early treatment of mental diseases, that were, importantly, to loosen the legal restrictions on the trade of lunacy that as governed by the 1890 Act.[118] Voluntary admission would enable private psychiatric institutions to attract clients who disliked legal certification, while general hospital psychiatry - the establishment of psychiatric branches at general hospitals - could provide psychiatric consultants and practitioners with a site to recruit private patients outside of legal controls.

[118] In addition, behind their emphasis on the humanitarian and scientific reasons, psychiatrists suggested political measures that would liberalise their trade of lunacy. The abolition of Section 315 that was proposed in the 1899 bill would allow psychiatrists to receive mental patients outside the Lunacy Laws, and the 1904 bill would virtually abolish restrictions on the extension of private mental health institutions in the cases of early treatment of mental diseases.

Chapter Three. The Structure of the Psychiatric Profession: Rise of Consulting Business, 1890-1914

Introduction

Behind the early treatment of mental disorder was, to some extent, a change in the personal economy of psychiatrists that was caused through the 1890 Act's restriction on private asylum business. After 1890, this restriction lessened job opportunities in the private sector of psychiatry that provided psychiatrists with money and fame. They could no longer make their career paths interactively between the public and private sectors, although they had done so in the mid-nineteenth century.[1] Frustrated by the restriction on its upward mobility, this chapter argues, the psychiatric profession sought a new way of making their career paths: consulting business. This rise of psychiatric consultancy, as well as the ideological move to mental hygiene,[2] helps us to understand why psychiatrists promoted general hospital psychiatry, an important suggestion in the early treatment discourses after 1890.

In previous histories, the 1890 Act has not been argued in terms of psychiatrists' personal careers. Only Charlotte Mackenzie analysed that between 1890 and 1917 private asylum doctors resisted the 1890 Act because of its restrictions.[3] However, her study limited its scope to private asylum doctors only. But, the 1890 legislation economically permeated the profession, specifically

[1] William Ll. Parry-Jones, *op.cit.*, pp. 79-80.
[2] Mathew Thomson, *op.cit.*, 2006, pp. 186-191.
[3] Charlotte Mackenzie, *op.cit.*, 1992.

through its impact on the structure of careers. It should be noted, however, that the thesis does not, although highlighting a determinant of economy in psychiatric politics, think little of the important function of general hospital psychiatry in terms of psychiatric doctors' long-term project to improve the educational system. Rather, it explores the materialistic concerns underlying psychiatric politics.

To examine the changing career paths of psychiatrists, this chapter uses the membership list of the MPA, focusing on the members working in England and Wales. The membership list were attached to the *Journal of Mental Science* annually, providing individual name, joining year and brief notes on each position for asylum doctors from 1890. Based on these lists, this chapter constructs a database of the occupational information of English psychiatrists in 1890 and 1914, and analyses their career paths in relation to the 1890 Act's restriction on private asylums. The database includes information taken from medical directories and probate calendars.[4] The latter illuminates the site of wealth of the psychiatric profession that was changing after 1890.

Overall, this chapter demonstrates that the 1890 Act altered the personal economy of psychiatrists to consultant-centric. In doing so, it argues that they sought a new political direction that would benefit their new economy, the early treatment of mental disorder.

[4] *Medical Directory* provides registered doctors' names, addresses, educational profiles, degrees and licentiates, current appointments, previous appointments and publications. Though, not all entries can provide so. The *Probate Calendars* (*Calendars of the grants of probate ... made in ... HM court of probate [England and Wales])* are held by the Probate Department of The Principal Registry Family Division (First Avenue House, 42-49 High Holborn, London, WC1V 6NP).

1. The Medico-Psychological Association and English Psychiatrists

The Origin of the MPA

In 1841, fourteen asylum doctors held a meeting at Nottingham, where Andrew Blake, the visiting physician to the Nottingham Asylum, declared the establishment of the Association of Medical Officers of Asylums and Hospitals for the Insane.[5] Its membership was limited to medical superintendents of public asylums. Doctors who had not worked at asylums were not eligible. The members, however, increased steadily, reaching 120 in 1854.[6] This was because of the expansion of public asylums after the Lunatics Act of 1845 which compelled local authorities to establish them.

From 1865, the Association accelerated its professionalisation by extending its membership to all the qualified doctors. It also changed its name into the Medico-Psychological Association. The renamed organisation successfully recruited private asylum proprietors and assistant medical officers of asylums.[7] At the same time, psychiatric doctors established their new identity, by designating themselves 'medical psychologists' and 'alienists' and their special field as 'medical psychology.'[8] Academically, too, their presence became apparent; they contributed significantly to various medical journals, such as *Brain*, *The Lancet*, and the *British Medical Journal*.

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[5] Edward Renvoize, *op.cit.*, 1991, pp. 34-40; Also see Trevor Turner, *op.cit.*, 1991, pp. 3-16.
[6] *Ibid.*
[7] In the membership list of 1890, 41 of 45 private asylum proprietors participated in the MPA after 1860 (*Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii).
[8] Some asylum doctors were fond of such general terms in medicine as 'physician,' not alienists.

In 1890, the MPA had about 400 members and began publishing its membership in the *Journal of Mental Science*. Hence, the year of 1890 was not merely a legal watershed but a crucial moment in psychiatric professionalisation.

The Regional Distributions of the MPA, 1890-1914

Between 1890 and 1914, the MPA achieved a 175.9 percent increase in its members. This is far beyond the national population growth. Along with this development, in England and Wales, the ratio of a psychiatrist to the general population was improved from 1:102,000 to 1:76,000. However, English psychiatrists were proportionately fewer than in Scotland and Ireland. Their uneven distribution shows that England remained a backward country in terms of psychiatry.[9]

[9] English psychiatrists regarded the Scottish counterpart as progressive (*Lancet*, February 1, 1902, p. 319). The high evaluation was drawn from the late nineteenth-century innovation of the Scottish Board of Lunacy which promoted non-asylum care for the insane: 'boarding-out' and 'family care' (D.K. Henderson, *op.cit*, 1964; Jonathan Andrews, *"They're in the trade ... of lunacy, they 'cannot interfere' - they say": the Scottish Lunacy Commissioners and lunacy reform in nineteenth-century Scotland*, London: Wellcome Trust, 1998).

Table 3-1. The Regional Distribution of the MPA Members, 1890 and 1914

	1890				1914				
	No.	Proportion to (A)	Population (in thousands)	Proportion to (B)	No.	Growth Rate	Proportion to (C)	Population (in thousands)	Proportion to (D)
Total	395 (A)		36,770 (B)		695 (C)	175.9%		46,048 (D)	
England & Wales	282	71.4%	28,764	78.2%	483	171.3%	69.5%	36,967	80.3%
Scotland	47	11.9%	4,003	10.9%	102	217.0%	14.7%	4,747	10.3%
Ireland	38	9.6%	4,003	10.9%	50	131.6%	7.2%	4,334	9.4%
Overseas	26	6.6%	N/A		56	215.4%	8.1%	N/A	
Unidentified	1	0.3%	N/A		4	400.0%	0.6%	N/A	

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Ibid.*, Vol. 60, 1914, pp. i-xxix.

In England and Wales, one out of four psychiatrists was in the London's metropolitan area. This distribution did not vary largely from 1890 to 1914, but a slight concentration in the metropolitan area is observed. In the provinces, such leisure cities as Bath, Brighton, Bournemouth and the Isle of Wight, attracted many psychiatric doctors working in the private sector. The other centre was in Yorkshire: this county had several larger lunatic asylums, such as the West Riding County Asylum at Wakefield, one of the country's eminent psychiatry institutions.

Table 3-2. The Regional Distribution of the MPA Members in England and Wales, 1890 and 1914

	1890		1914		
	No.	Proportions to (A)	No.	Growth Rate	Proportions to (B)
Total	282 (A)		483 (B)	171.3%	
Metropolitan	65	23.0%	115	176.9%	23.8%
Provinces	217	77.0%	368	169.6%	76.2%

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Ibid.*, Vol. 60, 1914, pp. i-xxix.

There were 248 psychiatrists in England in 1890, identified in Table 3-3 which excludes members who never experienced asylum work.[10] The great expansion between 1890 and 1914 was explained by Mathew Thomson as a result of the MPA's long-term strategy for improving the social status and scientific credibility of psychiatry.[11] In addition to this, the thesis emphasises that the increase was caused mainly by an increase in assistant medical officers at asylums, the rank and files of psychiatry. This is partly because the MPA's strategy, as Thomson argues, gradually let junior doctors join the fledging profession, and because the professional organisation democratised itself for professionalisation.

Another possible observation about them is that they were increasingly concentrated in the London between 1890 and 1914. The concentration was caused partly by the establishment of six new public asylums controlled by local authorities. In particular, the London County Council established new asylums at Claybury in 1893, at Bexley in 1898, at Epsom in 1899, at Horton in 1902 and at Long Grove in 1907. This, however, was not a sole reason for the increase, because metropolitan private asylums diminished at the time. The concentration is a key to understanding the economic impact of the 1890 Act on psychiatrists' career paths.

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[10] The non-psychiatrist members were physicians and surgeons to voluntary hospitals, medical officers of health to local authorities, medical officers of prisons, doctors of local infirmaries and dispensaries, and general practitioners. They were about ten percent of the MPA members in England and Wales, but few of them showed significant presence. For instance, Edward Clapton (1829-1909), physician to the St. Thomas Hospital and the MPA member from 1890, had no relation with psychiatry in his career. Rather, he was known for his works in botany and archaeology. Arthur Henry Boys, a general practitioner in St. Albans, was a clinical assistant in a consumption hospital, medical officer to the St. Albans Union, the Sick Club and Odd Fellows, and surgeon to the St Albans Hospital. Although his specialty of obstetrics might show his interest in puerperal insanity, he seems not connected with psychiatry (*Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Medical Directory*, London: John Churchill and Sons, 1890; 1914).

[11] On this ground, Thomson emphasises the importance of the Mental Deficiency Act of 1913, because it would, by improving the low cure rate and overcrowding in public asylums, enhance the status of psychiatry (Thomson, *op.cit.*, 1998, pp. 120-122).

Table 3-3. The Regional Distribution of Psychiatrists in England and Wales, 1890 and 1914

	1890		1914		
	No.	Proportion to (A)	No.	Growth Rate	Proportion to (B)
Total	248 (A)		418 (B)	168.54%	
Metropolitan	50	20.16%	97	194.00%	23.20%
Provinces	198	79.84%	321	162.12%	76.79%

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Ibid.*, Vol. 60, 1914, pp. i-xxix.

2. Categorisation of English Psychiatrists

To examine psychiatrists' career-making, this chapter classifies their occupational positions into nine categories: (1) consultant, (2) semi-consultant, (3) proprietor of private asylums, (4) medical superintendent of private asylums and registered hospitals, (5) medical superintendent of public asylums, (6) senior assistant medical officer, (7) assistant medical officer, (8) the retired, and (9) the others.[12] It also subdivides these nine categories into seventeen, according to whether they were in the metropolitan area or in the provinces, or whether they engaged in the private sector or the public sector. These categories are listed in Table 3-4, and the definitions of the major nine categories are given below.

[12] The nine categories are based on three major criteria: whether the psychiatrist worked in the private sector or public sector, whether he or she worked at senior positions with an experience of medical superintendence of asylums, whether he or she worked in the metropolitan area or provincial area. These were crucial in making differences in psychiatrists' income and status.

Table 3-4. The Internal Classification of English Psychiatrists

Class [1] Consultant	**Class [5] Superintendent in the Public Sector**
[1-A] in the Metropolitan Area	[5-A] in the Metropolitan Area
[1-B] in the Provinces	[5-B] in the Provinces
Class [2] Semi-Consultant and Practitioner	**Class [6] Senior Assistant Medical Officer**
[2-A] in the Metropolitan Area	[6-A] in the Private Sector
[2-B] in the Provinces	[6-B] in the Public Sector
Class [3] Proprietor	**Class [7] Assistant Medical Officer**
[3-A] in the Metropolitan Area	[7-A] in the Private Sector
[3-B] in the Provinces	[7-B] in the Public Sector
Class [4] Superintendent in the Private Sector	**Class [8] Retired**
[4-A] in the Metropolitan Area	**Class [9] Others, Non-psychiatrist positions**
[4-B] in the Provinces	[9-A] in the Metropolitan Area
	[9-B] in the Provinces

According to the definition of late nineteenth-century general medicine, consulting doctors (Class 1) were established practitioners. Their clients were from the upper and middle classes who could pay 'a guinea or more for each consultation or visit.'[13] To recruit such wealthy patients, consultants sought appointments at general hospitals and memberships of medical and gentlemanly societies: for example, fellowship of the Royal College of Physicians, London, and of Surgeons in England.[14] Through these connections, they could earn much higher fees than general practitioners. In this context, London was the best place for them to practice. Not a small number of London consultants left more than £ 100,000 on their death. Not only did they prosper economically, but they were political leaders within the

[13] Brian Abel-Smith, *The hospitals, 1800-1948: a study in social administration in England and Wales*, London: Heinemann, 1964, p. 110.

[14] There were 14 fellows of the Royal College of Physicians in the MPA in 1890: Fletcher Beach, George Fielding Blandford, James Crichton Browne, John Charles Bucknill, J. Langdon Haydon Down, J Hitchman, William Julius Mickle, Henry Monro, William Orange, Thomas C Shaw, R. Percy Smith, Daniel Hack Tuke, William Wood, and T. Outterson Wood (*Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii).

profession. In psychiatry, 'consultant' meant such elite practitioner specialising in the treatment of mental diseases.

Another prosperous occupational rank in psychiatry was proprietor of a private asylum (Class 3). They were the commercial providers of mental health services. Eligibility for such proprietorships was not limited to doctors. The 1890 Act stated that private asylums had to have medical staff, but did not stipulate that the proprietorship had to be a doctor. Indeed, laypersons could operate private asylum businesses.[15] Moreover, the existing proprietorship was transferable, so that it was often succeeded by family members in charge of the institution.[16] However, the Lunacy Commissioners argued for the control of private asylums under psychiatrists, on grounds of their experiences, connections, and specialised knowledge.[17] For psychiatrists, private asylums were an important means to a higher and wealthier position not only in psychiatry, but also in medicine and society. Hence, consultants and private asylum proprietors were senior positions for elite psychiatrists.

Steps to the senior occupational positions were through medical superintendentships of private institutions (Class 4) and public asylums (Class 5). The difference between the two categories was the salary. While most superintendents of registered hospitals and private asylums were paid more than

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[15] Proprietorship of private asylums was often taken by laypersons and spouses of the existing medical proprietor. This is exemplified in the case of Hendon Grove, a private asylum in London, which was run by Dr. H. Hicks and Mrs Hicks.

[16] There were many private asylums run as family business: for instance, Manor House located in Chiswick. It was run by Tuke's family: specifically, T. Seymour Tuke, Charles M. Tuke and the other family members. They became a joint proprietor of the asylum without longer services in other asylums. Reginald J. Stilwell also became the proprietor of Moorcroft House, a London private asylum, after having served as assistant house physician to Westminster Hospital and Bethlem Royal Hospital.

[17] Medical proprietors of private asylums did not have to be experts in mental disease; in the late nineteenth century, such non-psychiatric doctors as H. Hicks, the surgeon of the South Division of the Metropolitan Police, obtained private asylum proprietorship.

£ 1,000 a year,[18] annual salaries of public asylum superintendents were usually between £ 400 and £ 800.[19] Exceptionally, some progressive public asylums paid higher salaries to the superintendents. Robert Armstrong-Jones, medical superintendent of the London County Council Asylum at Claybury, received £ 1,000 per annum in 1894, when he was appointed.[20] A further difference was that the private sector's doctors could receive extra bonuses, when the institution prospered financially.

Apart from the salary issue, also important was that public asylum's works were administrative rather than medical and clinical. In public asylums, doctors had fewer occasions to have 'bedside talk' with patients, a clinical manner that was required of gentlemanly physicians. In addition to this, it was disgraceful in the physician's culture that most of the public asylum patients were incarcerated involuntarily under the control of the Home Office.[21] By contrast to the physicians' ideal of voluntarism and individualism, the public asylum was a site of law and order.[22]

Some doctors operated private practices, after having been in junior positions at lunatic asylums. Their economic and social positions were inferior to consulting

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[18] At the Bethlem Royal Hospital, in 1894, the physician superintendent had only £ 750 a year at the time (*Annual Report of the Bethlem Royal Hospital*, 1894: Bethlem Royal Hospital Archive). In most cases, salaries were raised gradually. In 1893, the annual salary of Robert Percy Smith was raised from £ 650 to £ 750 after his five-year service. George Savage received £ 900 in his final years (*Ibid.*, 1883-1893).

[19] The Holloway Sanatorium, a registered hospital in Surrey, paid its superintendent between £ 1000 and £ 1300 per annum; senior assistants £ 300; assistant medical officers between £ 150 and £ 200; and junior assistant medical officers £ 100. (2460/1-1-9: Annual Reports of the Holloway Sanatorium; Surrey History Centre). On the other hand, public asylum doctors were underpaid; the Somerset and Bath Lunatic Asylum offered a salary of £ 450 per annum for a new medical superintendent in 1896 (*Lancet*, September 12, 1896, p. 793), and the Sunderland Borough Lunatic Asylum did £ 350 per annum in 1894 (*Ibid.*, June 16, 1894, p. 1539). Some local asylums, exceptionally, like the Kent County Lunatic Asylum at Chartham offered its medical superintendent £ 600 per annum in 1892 (*Ibid.*, February 6, 1892, p. 341).

[20] *Ibid.*, November 5, 1892, p. 1081.

[21] *Journal of Mental Science*, October, 1893, pp. 480-481.

[22] See Christopher Lawrence, 'Incommunicable knowledge: science, technology and the clinical art in Britain 1850-1914,' *Journal of Contemporary History*, 1985, pp. 502-520.

psychiatrists. However, they could earn more income than public asylum superintendents by obtaining honorary positions at general hospitals and infirmaries. By giving up establishing their careers in public asylums, they found a way to secure a medical living. For this kind of practitioner, this thesis uses the term 'semi-consultant' (Class 2).

Senior assistant medical officers (Class 6) and assistant medical officers (Class 7) of asylums were at the lower end of the psychiatric profession. Typically, several assistant medical officers and a senior assistant medical officer were employed. A small number of educational institutions received young doctors under training: namely, the Bethlem Royal Hospital and West Riding County Asylum at Wakefield. Larger public asylums employed around five assistants. The ordinary assistants were paid between £ 100 and £ 150 per annum in the late nineteenth century;[23] senior assistants several hundred pounds.[24] The salaries were not low; doctors of local dispensaries and infirmaries were usually paid between £ 80 and £ 120.[25]

3. The Stagnation of the Psychiatric Job Market After the Lunacy Act of 1890

The 1890 Act impacted on the distribution of the above categories. Before explaining the shift, this chapter describes a successful career path of the pre-1890 psychiatrists. Most of these men started off as assistant medical officers in public

[23] The Wiltshire County Asylum provided £ 100 a year for its assistant medical officer (*Lancet*, November 1, 1890, p. 954), and the Hampshire County Asylum paid £ 100 for its third assistant medical officer (*Ibid.*, September 12, 1896, p. 793). In addition, the London County Council Asylum at Cane Hill paid £ 150 for its assistant medical officer (*Ibid.*, February 6, 1892, p. 341).
[24] In 1890, the Kent County Asylum at Maidstone paid £ 250 a year for the senior assistant medical officer (*Ibid.*, March 29, 1890, p. 730).
[25] In 1896, the Worksop Dispensary in Nottinghamshire offered £ 120 for candidates applying for its house surgeon (*Ibid.*, September 12, 1896, p. 793). The District Infirmary at Aston-under-Lyne paid £ 90 a year for its house surgeon (*Ibid.*, June 16, 1894, p. 1539).

asylums. This was the most popular path to participation in the psychiatric trade. A limited number of assistants were promoted successfully to senior assistant medical officers, though exceptionally, some of the assistant medical officers became medical superintendents directly. The promotion to medical superintendence was usually slow, depending on vacancies that occurred after the resignation of the existing medical superintendent. Among medical superintendents, a few were able to gain senior positions in the private sector: consultants, private asylum proprietors, and medical superintendents of private asylums and registered hospitals.

There were some doctors who began their career in the private sector, employed as assistant medical officers to private asylums and registered hospitals.[26] Here, promotion in the private sector was slower than in the public sector, since senior positions were held longer. Private sector psychiatry monopolised wealth and prestige.

The most significant change resulting from the 1890 Act took place at the top of the professional hierarchy. The cause was Section 207 of the Act which restricted the further expansion of private asylums. This forced elite psychiatrists to take a new direction in making their career paths - to become a mental consultant. As Table 3-6 shows, while private asylum proprietors decreased in proportion from 27.1 to 21.1 percent, consultants and semi-consultants increased from 22.9 percent to 29 percent. Compared to the general growth rate of 131.33 percent, the rise of psychiatric consultancy can be observed clearly in the post-1890 period. This trend is also remarkable in London and Middlesex. Table 3-7 shows that psychiatric

[26] Gilbert E. Mould was a successful psychiatrist who had spent his career only in the private sector. After having served as house physician to St. Mary's Hospital, he became assistant medical officer to Peckham House, a private asylum in London. Later he became medical superintendent of the Northumberland House Private Asylum in London and finally obtained the proprietorship of the Grange, a provincial private asylum at Rotherham.

consultants and practitioners had a marked 160.53 percent increase. Hence, the development of the private sector depended largely on elite and junior practitioners.

Table 3-5. The Internal Structure of English Psychiatrists, 1890 and 1914

	1890		1914		
	No.	Proportion to (A)	No.	Growth Rate	Proportion to (B)
Class [1] Consultant	**24**	**9.68%**	**36**	**150.00%**	**8.61%**
[1-A] Metropolitan	12	4.84%	21	175.00%	5.02%
[1-B] Province	12	4.84%	15	125.00%	3.59%
Class [2] Practitioner	**14**	**5.65%**	**25**	**178.57%**	**5.98%**
[2-A] Metropolitan	4	1.61%	10	250.00%	2.39%
[2-B] Province	10	4.03%	15	150.00%	3.59%
Class [3] Proprietor	**45**	**18.15%**	**46**	**102.22%**	**11.00%**
[3-A] Metropolitan	20	8.06%	14	70.00%	3.35%
[3-B] Province	25	10.08%	32	128.00%	7.66%
Class [4] MS Private	**18**	**7.26%**	**20**	**111.11%**	**4.78%**
[4-A] Metropolitan	4	1.61%	3	75.00%	0.72%
[4-B] Province	14	5.65%	17	121.43%	4.07%
Class [5] MS Public	**65**	**26.21%**	**91**	**140.00%**	**21.77%**
[5-A] Metropolitan	5	2.02%	11	220.00%	2.63%
[5-B] Province	60	24.19%	80	133.33%	19.14%
Class [6] Senior Asst	**19**	**7.66%**	**57**	**300.00%**	**13.64%**
[6-A] Private	6	2.42%	5	83.33%	1.20%
[6-B] Public	13	5.24%	52	400.00%	12.44%
Class [7] Asst	**53**	**21.37%**	**100**	**188.68%**	**23.92%**
[7-A] Private	8	3.23%	28	350.00%	6.70%
[7-B] Public	45	18.15%	72	160.00%	17.22%
Class [8] Retired	**1**	**0.40%**	**14**	**1400.00%**	**3.35%**
Class [9] Others	**9**	**3.63%**	**29**	**322.22%**	**6.94%**
[9-A] Metropolitan	0	0.00%	6	N/A	1.44%
[9-B] Province	9	3.63%	23	255.56%	5.50%
Total	**248 (A)**		**418 (B)**	**168.55%**	

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Ibid.*, Vol. 60, 1914, pp. i-xxix; *Medical Directory*, London: John Churchill and Sons, 1890; *Ibid.*, 1914.

Table 3-6. The Internal Structure of Senior English Psychiatrists, 1890 and 1914

	1890		1914		
	Number	Proportion to (A)	Number	Growth Rate	Proportion to (B)
Class [1] Consultant	**24**	**14.46%**	**36**	**150.00%**	**16.51%**
[1-A] Metropolitan	12	7.23%	21	175.00%	9.63%
[1-B] Province	12	7.23%	15	125.00%	6.88%
Class [2] Practitioner	**14**	**8.43%**	**25**	**178.57%**	**11.47%**
[2-A] Metropolitan	4	2.41%	10	250.00%	4.59%
[2-B] Province	10	6.02%	15	150.00%	6.88%
Class [3] Proprietor	**45**	**27.11%**	**46**	**102.22%**	**21.10%**
[3-A] Metropolitan	20	12.05%	14	70.00%	6.42%
[3-B] Province	25	15.06%	32	128.00%	14.68%
Class [4] MS Private	**18**	**10.84%**	**20**	**111.11%**	**9.17%**
[4-A] Metropolitan	4	2.41%	3	75.00%	1.38%
[4-B] Province	14	8.43%	17	121.43%	7.80%
Class [5] MS Public	**65**	**39.16%**	**91**	**140.00%**	**41.74%**
[5-A] Metropolitan	5	3.01%	11	220.00%	5.05%
[5-B] Province	60	36.14%	80	133.33%	36.70%
Total	**166 (A)**		**218 (B)**	**131.33%**	

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Ibid.*, Vol. 60, 1914, pp. i-xxix; *Medical Directory*, London: John Churchill and Sons, 1890; *Ibid.*, 1914.

Table 3-7. The Sectional Distribution of Senior English Psychiatrists, 1890 and 1914

	1890		1914		
	Number	Proportion to (A)	Number	Growth Rate	Proportion to (B)
Private Sector: Total	101	60.84%	127	125.74%	58.26%
Consultants/Practitioners	38	22.89%	61	160.53%	27.98%
Proprietors/Superintendents of private institutions	63	37.95%	66	104.76%	30.28%
Public Sector: Total	65	39.16%	91	140.00%	41.74%
Superintendents of public institutions	65	39.16%	91	140.00%	41.74%
Total	166 (A)		218 (B)	131.33%	

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Ibid.*, Vol. 60, 1914, pp. i-xxix; *Medical Directory*, London: John Churchill and Sons, 1890; *Ibid.*, 1914.

The proportional decrease of private asylum proprietors was a result of the 1890 Act. Its restriction on private asylums drove them gradually to disappear. The 82 private asylums that existed in 1890 decreased to 65 by 1909.[27] It should be noted that the decrease of private asylums had continued since the late nineteenth century. However, this does not show that the 1890 Act did not affect the private asylum business. Rather, it can be said that the pre-1890 decrease was caused partly by Lunacy Commissioners who made asylums to be controlled by professional and medical proprietors, excluding lay proprietors gradually. The other reason was that along with the expansion of public asylums, private asylums that mainly dealt with pauper patients disappeared.

Importantly, the post-1890 decrease of private asylums jeopardised the availability of senior appointments for psychiatrists; the surviving private asylums tended to transfer the proprietorship to its family members and a limited number of closely connected doctors.[28] This is what Peter MacCandless and Charlotte MacKenzie refer to as the 'monopoly' of the private asylum business.[29] The exclusive preservation of the vested interests in the private asylum business was criticised by contemporary psychiatrists. Robert Armstrong-Jones stated in 1903 that the 1890 Act created 'a monopoly' in the private asylum business.[30] In the Royal Commission which took place between 1924 and 1926, several psychiatrists also criticised the monopoly of the private asylum business. The monopoly is also confirmed in the fact that no public asylum superintendent in 1890 could become a proprietor of private asylums between 1890 and 1914. Table 3-8 supports to this

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[27] *Ibid.*

[28] Before 1890, successful public asylum doctors could often obtain proprietorship of private asylums, but it became unseen by 1914. For the private asylum business was monopolised by a limited number of families such as Finchs, Foxs, and Monros (Charlotte MacKenzie, *op.cit.*, pp. 12-13).

[29] *Ibid.*, p. 204; Peter MacCandless, *op.cit.*, 1983, p. 98.

[30] *Lancet*, December 26, 1903, p. 1778.

view. New proprietors were family members of the existing proprietors, or doctors who had established close relations with them. The traditional private market of psychiatry, which centred on private asylums, was closed.

The rise of London's consultant business is observed more clearly in the cases of those who had not established their positions by 1890. They were specifically the generations that joined the MPA in the 1870s, 80s and 90s. By 1914, most of the psychiatrists, who had joined the MPA between 1841 to the 1860s, retired or died after enjoying lucrative practices in the private sector, especially through the private asylum business. However, most of the psychiatrists who had participated in the MPA between the 1870s and 1890s had difficulty in finding senior positions in the private sector. None of the 1870s generation with 72 MPA members could obtain proprietorship of private asylums, whereas 8 of them successfully became psychiatric consultants. After 1890, if they wanted to be a social climber in the profession, they had to become a consultant. This trend is shared by the later generations.

Table3-8. Career Paths of Public Asylum Superintendents, 1890-1914

Samples	**28**	
London Consulting Doctor	4	14.3%
Provincial Consulting Doctor	2	7.1%
In the Same Position	14	50.0%
Retired	6	21.4%
State Administrator	1	3.6%

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Ibid*, Vol. 60, 1914, pp. i-xxix; *Medical Directory*, London: John Churchill and Sons, 1890; *Ibid*, 1914.

Table 3-8 also suggests that while capable public asylum superintendents became a consulting doctor, most of them were forced to remain a public asylum

doctor until retirement. 10 out of 14 retired MPA members in 1914 were ex-superintendents of public asylums in 1890. Their longer services at public asylums possibly caused a delay in the promotion of the lower class of psychiatrists, and drove them to opening private practices without the experience of asylum superintendence. This explains the increase of semi-consultants in the post-1890 period.

By 1914, Harley Street was dense with mental consultants: eminently, Robert Percy Smith was at Queen Anne Street, Thomas Claye Shaw at Weymouth Street, Maurice Craig (1866-1935) at Welbeck Street, Theophilus Bulkeley Hyslop (1863-1933) at Portland Street, G. E. Shuttleworth (1840-1928) at New Cavendish Street, and Henry Rayner and J. F. Woods (1856-1947) at Harley Street. It is after 1890 that psychiatric consultants flooded into the West End. However, there are not many written evidences that show the actual practices of psychiatric consulting doctors, except Janet Oppenheim's work on psychiatric practice of nervous patients and Virginia and Leonard Woolf's vivid recollections of her consulting psychiatrist, George Henry Savage.[31]

Private asylum proprietors joined the Harley Street consulting market, because they were afraid that full-time consulting psychiatrists would recruit wealthier clients. By 1914, Reginald L. Langdon-Down (1866-1955), the proprietor of the Newland House at Tooting Bec, had a consulting room at Welbeck Street; Reginald Stilwell, the proprietor of Moorcroft House, at Upper Berkeley Street; Charles Molesworth and T. Seymour Tukes at Wimpole Street. To have more inpatients from wealthier classes, private asylum proprietors and psychiatric consultants competed with each other in the heart of the capital.

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[31] Janet Oppenheim, *op.cit.*, pp. 31-34; p.107.

The stagnation of the psychiatric job market is also found in the fact that a significant number of psychiatrists left the MPA after 1890. 171 out of 250 English psychiatrists listed in 1890 disappeared by 1914. Among them were mostly junior doctors. 52 senior assistants and assistant asylum doctors in 1890 left the MPA after 1890. For example, G. D. Symes, the senior assistant medical officer of a provincial public asylum in 1890, later became an army medical officer and physician to a hydropathic establishment. After having been the clinical resident to St Luke's Hospital for Mental Diseases, W. Habgood became an assistant medical officer of a public asylum in the province, but gave up this, thereby becoming a local medical officer of health. Leading psychiatrists regarded as serious the mass dropping-out of junior psychiatrists. In 1914, the MPA stated that it suffered from the constant want of assistant medical officers.[32] The staff shortage, it explained, was caused by the public profile of psychiatry stigmatised by the law and the public. It is partly true, but it is also true that post-1890 psychiatry could not provide its junior doctors an economic satisfaction with their careers. The 1890 Act brought serious stagnation to the personal economy of English psychiatrists.

4. The Site of Money of English Psychiatry, 1890-1914

Probate Records

Causing the stagnation to the personal career paths of psychiatrists, the 1890 Act affected the site where their money was accumulated; because of its restriction on

[32] *Journal of Mental Science*, October, Vol. 61, 1914, pp. 485-486.

private asylums, senior psychiatrists gradually employed a way of seeking wealth through consulting businesses.

To investigate the distribution of psychiatrists' wealth, this chapter uses the probate records of those who were members of the MPA in 1890 and 1914.[33] Among them, it examines 70 senior psychiatrists, about 20 percent of the total senior members during those years. This selection is based on a proportion of career categories. For example, it draws 6 samples from 26 doctors in the category of consultant in 1890. Some occupational categories, though, cannot meet the twenty-percent requirement because of the difficulty of investigating relatively unknown psychiatrists. Also, to prevent duplicate sampling both in 1890 and 1914, the sample selection follows the generational distribution within each occupational classification. That is, the samples of 1890 include more elder MPA members than those of 1914.

The use of the probate records is necessary due to the absence of annual income records for psychiatrists.[34] There are a few well-collected personal papers as that of G. E. Shuttleworth, a consulting psychiatrist and the late medical superintendent of the Royal Albert Asylum for Idiots in Lancaster. Such personal papers rarely contain financial materials. As Trevor Turner has suggested, doctors tended to dispose of their clinical and private papers for reasons of discretion.[35] This tendency is all the more likely in the case of doctors working in the private sector, where disclosures could overshadow business. For example, when the National Society for Lunacy Reform disclosed correspondences between the chairman of

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[33] As for probate records in general, see Jeremy Gibson and Else Churchill, *Probate Jurisdictions: Where to look for wills*, Birmingham: Federation of Family History Societies, 1997; Peter Walne, *English Wills*, Virginia: Virginia State Library, 1964.
[34] Anne Digby, *op.cit.*
[35] Trevor Turner, 'Henry Maudsley: psychiatrist, philosopher, and entrepreneur,' William Bynum, Roy Porter and Michael MacDonald (eds), *The anatomy of madness*, Vol. 3, 1985, p. 175.

Camberwell House, a private asylum in London, and its secretary in the 1920s, the secretary agreed not to make any statement or charges whatever against this institution, accepting hush money. The only possible means to see the actual finance of the private sector of psychiatry is from the Board of Control files on provincial private asylums' accounts taken in 1924, which are shown in Chapter 6. Hence, in examining the economy of psychiatry, probate records are one of the few sources.

However, there is a difficulty in using probate records to examine personal wealth, as they rarely reveal the precise wealth.[36] Some records show an extraordinarily smaller amount, compared to the case of the other doctors who had similar careers. For example, Henry Forbes Winslow was an eminent London consultant practicing at Portman Square and Uxbridge in 1890 and in Brighton in 1914. According to his probate record, he left only £ 152 on his death in 1918. Likely he created living trusts to his kin or friends to dispense his wealth before death to avoid inheritance taxes.[37] However, this thesis insists that, despite these limitations of the probate records, they remain promising for historians of psychiatry, because they give us the first picture of the personal economy of psychiatrists.

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[36] As for the controversy over the use of probate records for measuring personal wealth, see W. D. Rubinstein, '"Gentlemanly Capitalism" and British Industry 1820-1914, *Past and Present*, No. 132, 1991, pp. 150-170; Martin J. Daunton, '"Gentlemanly Capitalism" and British Industry 1820-1914: Reply,' *Past and Present*, No. 132, 1991, pp. 170-187.

[37] The living trust was popular in the late nineteenth century; according to a London Solicitor's letter to *The Times* in 1894, the upper and middle classes often avoided inheritance taxes 'by settlements or by transfer of property to children under arrangements of various kinds' or 'by investing money in inscribed or other securities in America and elsewhere.' (*Times*, April 19, 1894, p. 6). If the legislation of 1894 were applied to Winslow's wealth at death, he would be levied by the minimum rate of 1 percent. (Roy Douglas, *Taxation in Britain since 1600*, New York: St. Martin's Press, 1999, pp. 79-80). However, if he left wealth valued between £ 50,000 and £ 75,000, he could be levied 5 percent, between £ 2,500 and £ 3,750. (*Ibid.* Also see *Times*, April 21, 1894, p. 15).

Psychiatric Wealth in 1890

The economic champions of nineteen-century psychiatry were proprietors of private asylums. Table 3-9 shows that their average wealth on death was £ 43,726, which was far ahead of those in the other categories. The eleven samples include two doctors who left more than £ 100,000 at their death, and three whose wealth at death were more than £ 50,000. George Fielding Blandford (1829-1911) left £ 106,785 in 1911. His major appointments were as the proprietor of Munster House at Fulham and the visiting physician to Blacklands House and Otto House, private asylums in London. Alonzo Henry Stocker (1829-1910), the proprietor of Peckham House in London and late medical superintendent at the County Asylum at Grove Hall, created a probate grant of £ 123,993.

Table 3-9. The Wealth of English Psychiatrists at Death (1-1) 1890

1890								
	Range of Wealth at Death		Taken cases (A)	Proportion of (A) to (B)	Total MPA Members (B)	Average Wealth at Death	Total Wealth at Death (C)	Proportion to (C)
Class [1]	£141 -	£19,947	10	41.7%	24	£7,343	£176,232	5.4%
Class [2]	£459 -	£13,023	2	14.3%	14	£6,741	£94,374	2.9%
Class [3]	£18 -	£123,993	11	24.4%	45	£43,726	£1,967,654	59.9%
Class [4]	£4,728 -	£34,360	4	22.2%	18	£19,484	£350,712	10.7%
Class [5]	£382 -	£16,883	8	12.3%	65	£5,811	£377,683	11.5%
Total	£18 -	£123,993	35	21.1%	166	£19,780	£3,283,546	100.0%

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Probate Calendars* (the Probate Department of The Principal Registry Family Division); Jim O'Donoghue, Louise Goulding and Grahame Allen, 'Comsumer Price Inflation since 1750,' *Economic Trends*, 2004, p. 43.

[1] **'Average Wealth at Death'** is the averaged amount of money estimated from the estate value.

[2] **'Total Wealth at Death'** is the estimated amount of money left by psychiatrists, based upon the 'Average Wealth at Death' and 'Total Number of the Members.'

The other cases of private asylum proprietors indicate a possibility of living trusts created before death, since the amount of their wealth was extraordinarily small. The wealth of C. T. Street (1857-1944), the proprietor of the Haydock Lodge in Lancashire, was only £ 18. However, this institution earned a surplus of £ 3,283 only in 1924, and he additionally received a salary as superintendent.[38] Similarly, it may be exceptional that John Kennedy Will (1857-1934), the proprietor of Bethnal House in London, left only £ 2,323 at his death. Bethnal House was a typical nineteenth-century London metropolitan private asylum which had flourished, receiving 110 private patients and 291 pauper patients in 1890. Thus, it is difficult to think that his proprietorship could only produce £ 2,323 at the time of his death. In addition, he must have received capital gains from his sale of that private asylum to local authorities in 1920.

Importantly, private asylum proprietors, 27 percent of senior psychiatrists, would represent 60 percent of the wealth of English psychiatrists as a whole. This is drawn from Table 3-9, specifically 'Total Wealth at Death' of private asylum proprietors at death that was calculated from the 'Average Wealth at Death' and 'Total MPA Members.' Even if I exclude the two cases of Blandford and Stocker, psychiatric millionaires, the proprietors could occupy more than 50 percent of the psychiatric wealth. Hence, proprietorship of private asylums was a predominant financial resource for psychiatrists in the late nineteenth century.

Compared to private asylum proprietors, late nineteenth-century consulting psychiatrists accumulated relatively lesser wealth. Their average wealth of £ 7,343 was, apparently, not sufficient for gentlemanly London physicians. At maximum, they left £ 15,000 at death. Thomas Outterson Wood, though having operated a

[38] MH51/829.

private practice at Margaret Street near the Cavendish Square in London, left £ 14,748 at his death. Thomas Lawes Rogers (1829-1912), a provincial consultant in Blackheath and the late medical superintendent at a county asylum at Rainhill, created his probate grant of £ 13,115 in 1912. Psychiatric consultancy was not extensive in the private sector, except for a few great psychiatrists like Daniel Hack Tuke (1827-1895) and Charles Bucknill (1817-1897).

In contrast to privately working doctors, public asylum superintendents were financially disadvantaged. Their salaries were fixed at between £ 400 and £ 1,000 per annum without extra bonuses, although they were additionally provided with a house attached to the asylums, coal, light, washing, milk, gardens, servants, gas, and vegetables. To accumulate money, they had to work longer, since they were not given opportunities to operate in private practices. Such doctors occasionally earned more than £ 10,000. John Greig McDowall (1851-1906) served as medical superintendent at a county asylum in Yorkshire for 25 years until his death in 1906. His long-term administration contributed to his wealth at death, at £ 9,493. Compared to McDowall, D. G. Thomson (1857-1923) worked as a superintendent at a provincial county asylum for a longer period up to 1924, and created the probate grant of £ 16,883. Even these exceptional cases show the financial limit of public asylum superintendents. Most of them only left thousands of pounds.

Psychiatric Wealth in 1914

By the early twentieth century, English psychiatry gradually shifted its financial centre from private asylums to consulting doctors. Table 3-10 is illustrative,

focusing on the wealth of senior psychiatrists active in 1914. On the eve of the war, private asylum doctors were losing their market dominance, decreasing 73 percent in the Total Wealth at Death.[39] This sudden fall is because of the restriction of the 1890 Act which decreased their numbers from 82 to 67 between 1890 and 1914. While the 1890 Act indirectly promoted the development of consulting businesses, it stagnated the economic extension of private asylums.

Table 3-10. The Wealth of English Psychiatrists at Death (1-2) 1914

	1914							
	Range of Wealth at Death		Taken cases (A)	Proportion of (A) to (B)	Total MPA Members (B)	Average Wealth at Death	Total Wealth at Death (C)	Proportion to (C)
Class [1]	£2,887 -	£53,854	8	22.2%	36	£15,886	£571,883	19.5%
Class [2]	£5,722 -	£30,183	4	16.7%	24	£18,095	£434,286	14.8%
Class [3]	£1,410 -	£29,889	10	20.4%	49	£11,130	£545,380	18.6%
Class [4]	£4,924 -	£44,046	2	9.5%	21	£24,485	£514,185	17.5%
Class [5]	£4,559 -	£20,528	11	12.1%	91	£9,576	£871,375	29.7%
Total	£1,410 -	£53,854	35	15.8%	221	£13,288	£2,936,579	100.0%

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Probate Calendars* (the Probate Department of The Principal Registry Family Division); Jim O'Donoghue, Louise Goulding and Grahame Allen, 'Comsumer Price Inflation since 1750,' Economic Trends, 2004, p. 43.

However, as far as the surviving institutions were concerned, their finance was not seriously jeopardised. Even in 1924, the average private asylum could make £ 2,816 profit a year. Hence, it seems that the more private asylum proprietors might have created *inter vivos* trusts in 1914 rather than in 1890, because the tax rate rose throughout the early twentieth century.[40] However, it is certain that private asylum doctors were no longer the economic champions within psychiatry, since their presence in the private sector had also declined.

[39] *Annual Report of the Commissioners in Lunacy*, London, 1890-1914.
[40] Major tax increases took place in 1909, 1915, and 1919(Roy Douglas, *op.cit.*, p. 96; p. 111; p. 117)

While the prosperity of private asylum proprietors moved to a low ebb, the private-practice psychiatry increased its scale and extent. Its assumed wealth became four times that of 1890. Post-1890 consulting psychiatrists, in particular, significantly improved their financial possibilities. Robert Armstrong-Jones created the probate of £ 68,717 on his death in 1943, and Thomas Claye Shaw accumulated his wealth of £ 53, 854 up to 1927. They were full-time consulting psychiatrists of the post-1890 generations. They were eminent in psychiatry, but not compared to Maudsley, Bucknill and Chrichton-Browne, the grandees of late nineteenth-century psychiatry. After 1890, such 'fair elites' could access more wealth only through consulting businesses.

Along with the rise of psychiatric consultants, semi-consultants also had a chance to extend their wealth. One such case is that of Donald Maxwell Cox, who began operating a private practice in Bristol after having served as house physician to Bethlem Royal Hospital and assistant medical officer of health in Leicester. His wealth at death was £ 29,529. Semi-consultants were indeed unknown psychiatric doctors, yet they could have more wealth than average public asylum superintendents. Public asylum superintendents also gained wealth between 1890 and 1914, but this result still shows their financial limitations. The wealth on death that they could at maximum have did not increase so much between 1890 and 1914. Most of the public superintendents were forced to remain in the same public service for longer periods, and retired soon after resigning from their positions without obtaining private practices. Hence, their increased wealth simply shows that the extent to which they were underpaid was partly improved.

It should be noted that the monetary value was inflated increasingly in the early twentieth century; the price index rose from 8.8 to 17.3 between 1890 and

1930.[41] However, this does not affect the major trends that are observed above; Table 3-11 and 3-12 that adjust the wealth at death to the price indexes show little difference from the result of Table 3-9 and 3-10.

Table 3-11. The Wealth of English Psychiatrists at Death (2-1) 1890, Corrected by Price Indexes

	1890						
	Range of Wealth at Death	Taken cases (A)	Proportion of (A) to (B)	Total MPA Members (B)	Average Wealth at Death	Total Wealth at Death (C)	Proportion to (C)
Class [1]	£141 - £19,947	10	40.0%	25	£6,540	£163,488	5.8%
Class [2]	£459 - £13,023	2	14.3%	14	£6,130	£85,820	3.1%
Class [3]	£18 - £123,993	11	23.9%	46	£37,308	£1,716,155	61.4%
Class [4]	£4,728 - £34,360	4	22.2%	18	£14,815	£266,661	9.5%
Class [5]	£382 - £16,883	8	12.1%	66	£4,415	£291,390	10.4%
Total	£18 - £123,993	35	20.8%	168	£16,646	£2,796,566	100.0%

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Probate Calendars* (the Probate Department of The Principal Registry Family Division); Jim O'Donoghue, Louise Goulding and Grahame Allen, 'Comsumer Price Inflation since 1750,' *Economic Trends*, 2004, p. 43.

Table 3-12. The Wealth of English Psychiatrists at Death (2-2) 1914, Corrected by Price Indexes

	1914						
	Range of Wealth at Death	Taken cases (A)	Proportion of (A) to (B)	Total MPA Members (B)	Average Wealth at Death	Total Wealth at Death (C)	Proportion to (C)
Class [1]	£1,616 - £26,628	8	22.2%	36	£7,606	£273,915	19.6%
Class [2]	£2,576 - £14,520	4	16.7%	24	£7,558	£181,386	13.0%
Class [3]	£770 - £14,945	10	20.4%	49	£5,736	£281,059	20.1%
Class [4]	£2,689 - £21,076	2	9.5%	21	£11,883	£249,553	17.9%
Class [5]	£1,104 - £8,482	11	12.1%	91	£4,447	£404,694	29.0%
Total	£770 - £53,854	35	15.8%	221	£6,318	£1,396,366	100.0%

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Probate Calendars* (the Probate Department of The Principal Registry Family Division); Jim O'Donoghue, Louise Goulding and Grahame Allen, 'Comsumer Price Inflation since 1750,' *Economic Trends*, 2004, p. 43.

[41]); Jim O'Donoghue, Louise Goulding and Grahame Allen, 'Comsumer Price Inflation since 1750,' *Economic Trends*, 2004, p. 43.

In considering wealth at death, we should also pay attention to the familial backgrounds of psychiatrists, because the sum may not only show wealth from salaries and other medical income, but also indicate the case in which their marriage and other circumstances would affect their wealth. However, this speculation seems untrue; Table 3-11 shows that most of elite psychiatrists were from middle class families. Only a few of them attended Oxbridge for their pre-medical education; most went to cheaper London teaching hospitals.

Table3-13. Familial and Educational Backgrounds of FRCP Psychiatrists, 1890-1930

Samples		**24**
I. Familial Background	Clergymen	3
	Psychiatrists	2
	Chemist	2
	Medical Profession	1
	Legal Profession	1
	Bureaucrat	1
	Other Profession	2
	N/A	12
II. Pre-Medical Education	Grammar School	7
	College	4
	Oxbridge	3
	Apprentice	1
	N/A	9
III. Medical Education	London Teaching Hosp.	13
	London College Hosp.	7
	Local General Hosp.	1
	Other	1
	N/A	2
IV. Final Occupational Status	London Consultant	9
	Local Consultant	4
	London Proprietor	3
	Public Asylum's MS	3
	Local Proprietor	2
	State Appointment	2
	Other	1

Sources: G.H. Brown, *op.cit.*, 1955; Richard R Trail, *op.cit.*, 1968.

Overall, probate records of psychiatrists show that the centre of psychiatric wealth shifted from private asylums to private practices between 1890 and 1914. Born into middle-class families, they pursued money and fame thorough consulting businesses.

5. The Political Consequence of the Rise of Mental Consultants

Behind the personal economy of psychiatry that changed after 1890, psychiatric consultants demanded a new direction of general hospital psychiatry, specifically the establishment of a new psychiatric department in general and voluntary hospitals. This political demand has been understood in relation to humanitarian and preventive psychiatry.[42] However, it can be seen differently when we consider the context in which general hospitals were used as places to establish consulting practices.

Traditionally, these practices required personal connections with the rich. When physicians and surgeons obtained general hospital appointments, they needed contacts with hospital governors and subscribers, not with the patients. From the hospitals, they received only small honorariums. By using their hospital connections with the wealthier people, they earned money not in hospitals but through their private practices out of hospitals.

From the late nineteenth century when the medical market expanded into the middle classes, the medical profession sought extensive recruiting of clients. In their strategy, elite consulting doctors began exploiting outpatient departments at

[42] Mayou, R., 'The history of general hospital psychiatry,' *British Journal of Psychiatry*, 1989, pp. 764-776; Freeman, Hugh, 'The general hospital and mental hospital care: A British perspective,' *The Milbank Quarterly*, 1995, pp. 653-676.

general and voluntary hospitals. As Brian Abel-Smith demonstrated long ago, hospital physicians and surgeons recruited to their private practices patients who were originally seen by general practitioners at outpatient departments.[43] This was called 'hospital abuse' or 'outpatient abuse.' Because this new form of medical practices deprived them of custom, general practitioners were against the promotion of the outpatient facilities. It was in this context that psychiatry in general hospitals was disputed in medicine. It had strategic value in establishing medical livings especially in the age of the monopoly of the private asylum businesses. This, the thesis argues, is why elite psychiatric consultants demanded branch establishments in general hospitals.

Not only in their rhetoric, but in their practices, psychiatrists individually spared no effort in obtaining general hospital appointments after 1890. An example is Henry Rayner, an elite psychiatrist who began his career at the Bethlem Royal Hospital as assistant medical officer, and became medical superintendent of the male side of the London County Council Asylum at Hanwell between 1872 and 1888. In the ensuing years, he became a consultant physician especially dealing with mental diseases at Harley Street, obtaining lectureship and physician's position at the Middlesex Hospital and St. Thomas's Hospital. In 1892, Rayner worked on hospital colleagues to open an outpatient department for early treatment of psychiatric cases at St. Thomas's Hospital. In February 1893, as a result of his personal but strong request to the hospital authorities, the hospital decided to open an outpatient department for mental diseases.[44] Rayner gave weekly consultancies at St. Thomas's, while building up his private practice at Harley Street and at Upper

[43] See Chapter 7 and 11 in Brian Abel-Smith, *op.cit.*
[44] H01/ST/K/10/046 (London Metropolitan Archives).

Terrace House in Hampstead.[45] In 1905, his position at St. Thomas's was succeeded by Robert Percy Smith, another elite psychiatrist of Bethlem. Percy Smith too followed Rayner's path into consulting practice through the connection with general hospitals, his private office being at Queen Anne Street in the West End.

Rayner and Percy Smith's positions at St. Thomas's certainly functioned as an aid to their private practices.[46] Other psychiatric consultants followed them after 1890, all resorting to lucrative private practices: George Savage, George Henry Cole and Bernard Hart (1879-1966). This is shown in Table3-14.

[45] Rayner was not the first psychiatrist to combine his consulting practice with general hospital connections. This style of practice was pioneered by Henry Maudsley (1835-1918) in the late nineteenth century, who was lecturer for mental diseases at St. Mary's Hospital from 1867. He exploited this connection for his consultancy and private asylum, and became the foremost psychiatrist in the latter part of the nineteenth century. Very few psychiatrists, however, followed his path before 1890. Maudsley's political and practical stances were, as it is often said, foreign to other psychiatrists (Andrew Scull, Charlotte MacKenzie and Nicholas Hervey, *Masters of Bedlam: the transformation of the mad-doctoring trade*, Princeton: Princeton University Press, 1996, p. 242). It was only after 1890 that English psychiatrists followed Maudsley's individualistic way of medical practice.

[46] *Ibid.*

Table 3-14. The Major Appointments of Physician for Mental Diseases at London-Based General Hospitals, 1890-1930

Hospital 1: Charing Cross Hospital	
Position: Physician for Mental Disorders	
Dr. Robert Percy Smith	1902-05
Dr. Charles Mercier	1905-13
Dr. E.D. Macnamara	1913-
Hospital 2: Guy's Hospital	
Position: Lecturer in Mental Physiology in its relation to Mental Disorders	
Dr. George Savage	1871-1903
Position: Physician for Mental Diseases	
Dr. George Savage	1896-1903
Dr. Maurice Craig	1903-1926
Hospital 3: St. Mary's Hospital	
Position: Lecturer for Mental Diseases	
Dr. Henry Maudsley	1867-1881
Sir James Crichton-Browne	1881-1895
Dr. T. B. Hyslop	1895-1911
Position: Physician for Mental Diseases	
Dr. R. H. Cole	1911-1926
Hospital 4: St. Thomas' Hospital	
Position: Lecturer for Mental Diseases	
Henry Rayner	1878-1905
Position: Physician for Mental Diseases	
Henry Rayner	1893-1905
Hospital 5: University College Hospital	
Position: Lecturer in Mental Physiology and Mental Diseases	
Dr. Bernard Hart	1910-1913
Position: First physician to the Out-Patient Department for Mental Diseases	
Dr. Bernard Hart	1913-1947

Sources: William Hunter, *Historical account of Charing Cross Hospital and Medical School*, London: J. Murray, 1914, p. 162; Charles Cameron, *Mr. Guy's Hospital: 1726-1948*, London; New York: Longmans, Green, 1954, p. 358-359; *Ibid.*, 375-376; Zachary Cope, *The history of St. Mary's Hospital Medical School: or, A century of medical education*, Toronto : Heinemann, 1954, pp. 90-91; *Ibid.*, p. 236; H01/ST/K/10/046 (St. Thomas's Hospital Papers: London Metropolitan Archives); W.R. Merrington, *University College Hospital and its Medical School: a history*, London: Heinemann, 1976, pp. 226-229.

Not only general hospitals, but psychiatric hospitals were used for psychiatrists' private practices. In the early twentieth century, Bethlem doctors requested the Governors to permit them to have private consultations with the hospital's patients in London. Their intention was to use the institutional connection to extend their private services as other hospital physicians did.[47]

[47] Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker, and Keir Waddington, *op.cit*, p. 619.

Psychiatrists' self-interests in hospital resources were seen not only in psychiatry, but in general, medical consulting businesses developed steadily between the late nineteenth century to the early twentieth century.[48] Janet Oppenheim argued that:

> By the late nineteenth century, the demand for health services had grown to such an extent that a fairly high degree of medical specialisation was financially possible. Now certain psychiatrists could function solely as consultants in case of mental disorder, whether mild or acute, and they accordingly sought a clientele among the prosperous reaches of society.'[49]

Andrew Scull was of a similar opinion with regard to the rise of consulting businesses in the late nineteenth century.[50] Through increasingly specialised educational and institutional medical settings, psychiatry advanced its professionalism, theories and services.[51] . But, although the development of psychiatric consultancy and general hospital psychiatry might seem a logical and natural consequence of the times, it was also a part of politics for an alternative system to the 1890 Act. The thesis thus argues that psychiatrists were in need of new legislation fit for the new consultant-centric economy that the Act caused; the legislation that would produce senior appointments for psychiatrists that would assist their private practices.

Deprived of an entrepreneurial outlet through private asylums after 1890, English psychiatry began constructing a new form of medical practice and advocating the new legislation fit for the form. This strategy was successful. Table

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[48] See Chapter 15 in Abel-Smith, *op.cit.*

[49] Janet Oppenheim, *Shattered nerves: doctors, patients, and depression in Victorian England*, Oxford; Oxford University Press, 1991, p. 26. As for the rise of consulting business in medicine, also see M. Jeanne Peterson, *The medical profession in mid-Victorian London*, University of California Press, 1978, pp. 15-16;

[50] Andrew Scull, Charlotte MacKenzie and Nicholas Hervey, *op.cit.*, p. 9.

[51] *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Ibid.*, Vol. 60, 1914, pp. i-xxix.

3-15 shows that most of London's consulting psychiatrists earned far more wealth than doctors who ended their careers as public asylum superintendents. They were not the greatest psychiatrists like Maudsley or Bucknill, but able to earn money like them.

Table 3-15. A List of Selected Leading Consulting Psychiatrists and Their Wealth at Death, 1890-1930

Name	Wealth at Death	Price Index	Wealth at Death Corrected by Price Indexes	Brief Career
George Henry Savage	£ 27,038 (1921)	23.1	-	MS.(Bethlem Hosp.)- Consultant (Lond.)
Robert Henry Cole	£ 5,413 (1926)	18.5	£6,759	MS.(Lond. Private Asyl.)-Consultant (Lond.)
Henry Rayner	£ 41,334 (1926)	18.5	£51,612	MS.(Bethlem Hosp.)- Consultant (Lond.)
Thomas Claye Shaw	£ 53,954 (1927)	18	£69,241	MS.(Lond. Pub. Asyl.)- Consultant (Lond.)
T. Outterson Wood	£ 14,748 (1930)	17.3	£19,692	MS.(Prov. Private Asyl.)-Consultant (Lond.)
Maurice Craig	£ 55,066 (1935)	15.9	£80,002	MS.(Bethlem Hosp.)- Consultant (Lond.)
Ernest William White	£ 34,310 (1935)	15.9	£49,847	MS.(Lond. Pub. Asyl.)- Consultant (Lond.)
Nathan Raw	£ 11,450 (1940)	20.2	£13,094	Phys.(Prov. Infirmary)- Consultant (Lond.)
Robert Percy Smith	£ 7,936 (1941)	22.4	£8,184	MS.(Bethlem Hosp.)- Consultant (Lond.)
Helen Boyle	£ 25,292 (1957)	46.9	£12,457	Phys.(Neuro. Hosp.)- Consultant (Prov.)
Bernard Hart	£ 67,168 (1966)	60.7	£25,561	MS.(Lond. Private Asyl.)-Consultant (Lond.)
Average	**£31,246**		**£33,044**	
Cf. A case of a public asylum doctor who left the average amount of wealth at death for his occupational category				
P.E. Campbell	£ 10,802 (1927)	18	£5,341	Asst.-MS. (Prov. Pub. Asylum)

Abbreviations:

Asst. Assistant Medical Officer	MS. Medical Superintendent
Asyl. Asylum	Neuro. Neurological
Hosp. Hospital	Prov. Provincial
Lond. London	

Sources: *Journal of Mental Science*, Vol. 36, 1890, pp. i-xiii; *Probate Calendars* (the Probate Department of The Principal Registry Family Division); Jim O'Donoghue, Louise Goulding and Grahame Allen, 'Comsumer Price Inflation since 1750,' Economic Trends, 2004, p. 43.

Conclusion

The 1890 Act caused an economic crisis for the personal economy of the psychiatric profession. The Act's restriction on private asylums where psychiatrists could exercise privilege and gain wealth before 1890 caused a great change to the occupational hierarchy of the profession, and indirectly affected its political claim. A direct consequence of the Act was that the private asylum business, monopolised by the existing proprietors, declined throughout the period. The shrinking nature of the business inhibited doctors, who aspired to work in the private sector, from becoming private asylum proprietors. Because of this, senior psychiatrists had no alternative but to become consultants, if they wanted to work in the private sector. So did junior psychiatrists. As a result, consulting psychiatrists took over from private asylum proprietors as the core economic group in English psychiatry. A political consequence was the demand for general hospital psychiatry where clients could be recruited. Not only did the 1890 Act influence the individual economy of English psychiatrists, then, but it also did much to remake the institutional economy of English psychiatry.

Chapter Four. The Institutional Practice:

Rise of Voluntary Admissions, 1890-1914

Introduction

From an institutional perspective, this chapter examines why the English psychiatric profession claimed the necessity for the voluntary admission of mentally ill patients between 1890 and 1914. 'Voluntary admission' refers to the practice whereby patients decide to enter into a mental health institution of their own volition and without legal formalities.

Historians of psychiatry, somehow following contemporary psychiatrists' insistence, have long thought that voluntary admission was an important suggestion for the early treatment of mental disorder. That is, they have assumed the rightness of the humanitarian and scientific arguments brought forward for it by the psychiatric profession.[1] Moreover, they have done so largely without looking at the actual practice of voluntary admission.[2] Did psychiatrists actually use voluntary admission for early treatment of mental disease? Was it only patients who would benefit from the admission system? My answer is negative. Voluntary admission was a managerial technique of psychiatric institutions to meet a change in mental health users' attitude to psychiatry, which originated from the legal certification that the 1890 Act established.

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[1] Kathleen Jones, *op.cit.*, 1993, pp.136-138; Clive Unsworth, *op.cit.*, pp. 202-203.

[2] Some historians referred to voluntary admissions, but they provided only brief introduction of this system (William Ll. Parry-Jones, *op.cit.*, pp. 261-263; Charlotte MacKenzie, *op.cit.*, 1992, p. 107; Anne Digby, *Madness, morality, and medicine: a study of the York Retreat, 1796-1914*, Cambridge; Cambridge University Press, 1985, pp. 205-206).

Legal certification in lunacy impressed on the public, patients and their relatives that psychiatric admissions were a matter of law. This had a huge economic disadvantage for psychiatric institutions. As shown in Chapter 2, the upper and middle classes disliked even meeting a magistrate, feared public knowledge of the incarceration of their kin.[3] Hence, they were inclined to use non-psychiatric medical services provided by private nursing homes, foreign hostels, sanatoria, inebriate asylums, homeopathic and hydropathic institutions and so on, all of which were known to cater for, and advertised for, potentially mentally ill patients.[4] Non-psychiatric general practitioners, too, received nervous and mental patients in their own homes.[5] These 'secret' mental health services were exposed when authorities found a case of violation to Section 315 of the 1890 Act. For example, in 1898, Ernest Noel Reichardt, a practitioner who ran a nursing home at Ewell, was charged with taking a lunatic at an unlicensed premise without legal certification.[6] It was the tip of the iceberg; the Lunacy Commissioners found similar cases all over the country, and Table 4-1 also indicates that a small provincial nursing home run by a layperson could recruit patients around Britain.[7] The reason was obvious. For example, when a woman suffering from intermittent delusions was sent as a non-certifiable mental inmate to a private nursing home St. John's Nursing Institute at Upper-Holloway, her family thought that it was humiliating to let her certified

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[3] See Robert Percy Smith's insistence on the public dislike of legal certification in 1891 shown in Chapter 2. Also importantly, In the Royal Commission on Lunacy and Mental Disorder, many of ex-patients witnessed their dislike of legal certification and advantage of voluntary admissions to avoid legal certification. For instance, see Miss C's witness. She remarked that 'every means should be taken to avoid putting that [legal certification], because it is very difficult to live apart from it afterwards,' in response to a question whether 'certification should be delayed till the last possible' (*Minutes of the Royal Commision on Lunacy and Mental Disorder*, 1926, p. 623).
[4] Charlotte MacKenzie, *op.cit.*, pp. 99-102; pp. 201-202.
[5] Janet Oppenheim, *op.cit.*, p. 34.
[6] *Justice of the Peace*, June 25, 1898, p. 412.
[7] MH51/71 (National Archives, Kew).

legally as a lunatic.[8] The patient's cousin remarked to the police that if he had his cousin certified as a lunatic, he would be blamed by other relatives, so that the only way was that he should have 'taken her to some other place, hide her up, not had her certified.'[9] Nursing homes thus created a niche for patients not wishing to be considered as 'a certifiable lunatic.' As Robert Percy Smith had said, patients' relatives seem to dislike psychiatric institutions and seek illegal ones in avoidance of legal certification.

Table 4-1. A List of Patients at a Nursing Home in Matlock, 1902

Patient's Initial	Original Living Place	Payment per annum	Length of Stay (Month)
H. G. W.	Liverpool	£43.8	123
W. J. H.	London	£39.0	116
A. S.	Nottingham	£65.0	64
F. C. D.	Manchester	£39.0	62
C. E.S. S.	Salford	£60.0	26
W. K.	London	£45.5	26
E. S.	Leeds	£39.0	25
F. C.	Leeds	£19.5	12
J. F.	N/A	£54.6	10
J. B.	Southport	£54.6	7
P. K. B.	London	£52.0	5
Average		£46.5	43.3
Assumed Annual Income		£512.0	

Source: MH51/71.

In the post -1890 contest in which legal certification was abhorred, voluntary admission was an attractive service for the middle and upper classes. 'Early treatment' of mental disorder thus took on a particularly useful meaning; there was a practical reality behind that political rhetoric.

[8] *Ibid.*
[9] *Ibid.*

To the explication of this, the chapter takes as an example an institution from the private sector: Holloway Sanatorium, a relatively new registered hospital at Virginia Water in Surrey. This institution was eager to receive voluntary boarders in England and Wales between 1890 and 1914. Using records of the institution, the chapter describes the politics in which the institution manipulated the voluntary admission system for its survival in the mental health market.

This was not only Holloway's issue; behind the manipulation, private mental health institutions increased voluntary admission to approximately fifty percent of the total number of the psychiatric admissions by 1930.[10] As a result, they could regain approximately 10 percent of the bed occupancy. Through voluntary admission, private institutions of psychiatry secured their business that was jeopardised by the legalistic legislation of 1890, not achieving humanitarian and therapeutic provisions for patients.

1. Voluntary Admissions, 1862-1914

Voluntary admission into lunatic asylums was first introduced in the Lunatics Act Amendment Act of 1862.[11] This legislation granted power to managers of licensed houses and registered hospitals to receive voluntary patients.[12] Such patients were those who were 'not insane' but were 'conscious of a want of power of self-control, or of addiction to intemperate habits, or fearing an attack or a recurrence of mental disorder.'[13] In all respects, they were free agents without the legal and medical

[10] *Annual Report of the Board of Control*, 1930.
[11] 25 and 26, Vict., 1862, Ch. 111.
[12] William Ll. Parry-Jones, *op.cit.*, p. 25; *Ibid.*, p. 262.
[13] *Annual Report of the Commissioners in Lunacy*, 1863, pp. 12-13; *Lancet*, July 4, 1863, p. 25.

formality required, and technically called 'voluntary boarders,' not 'patients.' *The Times* called them 'half-mad.'[14]

To the voluntary admission system, the 1862 legislation attached a conditional regulation that only those who had been lunatics at asylums in the preceding five years were admissible as boarders. William Ll. Parry-Jones pointed out that this clause made voluntary admission somewhat paradoxical, because the less legalistic admission system was provided only for those who already had been involved with the legal procedure of lunacy.[15] Because of this discrepancy, until 1889, voluntary admission was not popular. Nor was it well known by doctors; only a few articles referred to this admission system in medical journals between 1862 and 1889.[16]

The 1890 Act abolished that condition, based upon the recommendation of the parliamentary Select Committee on Lunacy Laws of 1877, which was relatively inclined to meet psychiatrists' demands. The Committee stated that it seemed unnecessary to restrict voluntary admission to a person who had already been a certified patient.[17] The Commissioners in Lunacy, however, thought the opposite of this. They did not recommend voluntary admission of persons who had never been certified, because it would prompt managers of licensed houses to evade the law, by admitting persons who should be under certificates as boarders.[18] Regardless of this warning, Parliament enabled voluntary admission for the person who had never been certified as a lunatic in the Lunatics Act Amendment Act of 1889, later consolidated

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[14] *Times*, June 25, 1863, p. 7.
[15] William Ll. Parry-Jones, *op.cit.*, , p. 25.
[16] *Lancet*, July 4, 1863, p.25; *Ibid.*, December 10, 1887, p. 1203; *Ibid.*, December 17, 1887, p. 1252; *Ibid.*, December 24, 1887, p. 1303.
[17] *Report from the Select Committee on Lunacy Law, House of Commons*, H.M.S.O., 1877, p. vi; *Annual Report of the Commissioners in Lunacy*, 1878, p. 137.
[18] *Ibid.*

into the Lunacy Act of 1890.[19] It held, though, little debate on the voluntary admission system.[20]

As for the detail of the system, Section 229 of the 1890 Act prescribed that 'any person desirous of voluntarily submitting to treatment...may be received as a boarder.'[21] Under this clause, any person whose symptoms were uncertifiable could be admitted to private psychiatric institutions without legal formalities, would not be detained more than the period specified in the consent, and could leave the institution by giving 24 hours' notice. However, the prospective voluntary boarders had to obtain a previous written consent of one of the Lunacy Commissioners or two justices who had given a licence to the private asylum.[22] From 1891, moreover, the notice of voluntary admission had to be given to the Commissioners by the manager of the institution within twenty-four hours.

After 1890, psychiatrists expected voluntary admission to be a system alternative to the 1890 Act that was later called 'triumph of legalism.'[23] In the Section of Psychology of the BMA in 1891, George Henry Savage, an eminent psychiatric consultant in London, strongly advocated 'the extension of the system of voluntary boarders, as tending to break down the legal barriers which hamper and surround the present system of the reception of patients into asylums.'[24] Replying to Savage, Clifford Allbutt (1836-1925), one of the medical Commissioners in Lunacy, although pointing out the potential abuse of the system as placing dangerous lunatics in asylums as voluntary boarders and avoiding legal certification, remarked that that

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[19] 52 and 53, Vict., 1889, Ch.41.
[20] *Parliamentary Debates, House of Commons*, Vol. 333-340, 1889.
[21] *53 Vict., CH5*, Lunacy Act, 1890.
[22] *Ibid.*
[23] Kathleen Jones, *op.cit.*, 1993, pp. 93-95.
[24] *Lancet*, August 8, 1891, pp. 316-317; *British Medical Journal*, August 1, 1891, p. 242.

extension would be largely beneficial.[25] Regardless of the potential abuse publicly acknowledged, psychiatrists as a whole began promoting this system after 1890.

Up until the Great War, voluntary admission gradually increased. In 1891, there were only 119 voluntary boarders, 9 percent of the admissions in the private sector.[26] In 1914, however, their admissions reached 422, 16 percent of private sector's admissions, as depicted in Table 4-3. This 173 percent increase was significant, because admissions of certified patients in the private sector decreased 17 percent in the period.[27] Hence, by developing voluntary admission, the private sector of psychiatry prevented its decline.

[25] *Ibid.*
[26] *The Annual Report of the Commissioners in Lunacy*, 1891.
[27] The statistical information of voluntary boarders between 1910 and 1913 were not available, probably because of the reorganisation of the Commissioners in Lunacy into the Board of Control in 1913, which was based upon the recommendation of the Royal Commission on Mental Deficiency published in 1908.

Table 4-2. Certified Patients and Voluntary Boarders, 1890-1914

Year	Certified Patients	Growth Rate	Voluntary Boarders	Growth Rate
1890	85,082	N/A	N/A	N/A
1891	85,806	100.9%	119	N/A
1892	86,855	101.2%	134	112.6%
1893	88,853	102.3%	134	100.0%
1894	91,105	102.5%	132	98.5%
1895	93,111	102.2%	173	131.1%
1896	95,473	102.5%	143	82.7%
1897	98,376	103.0%	143	100.0%
1898	100,959	102.6%	142	99.3%
1899	104,055	103.1%	132	93.0%
1900	105,589	101.5%	138	104.5%
1901	106,928	101.3%	138	100.0%
1902	109,660	102.6%	148	107.2%
1903	112,887	102.9%	171	115.5%
1904	116,111	102.9%	156	91.2%
1905	118,704	102.2%	153	98.1%
1906	120,846	101.8%	146	95.4%
1907	122,860	101.7%	156	106.8%
1908	124,927	101.7%	165	105.8%
1909	127,602	102.1%	150	90.9%
1910	129,353	101.4%	N/A	N/A
1911	129,795	100.3%	N/A	N/A
1912	132,185	101.8%	N/A	N/A
1913	134,183	101.5%	N/A	N/A
1914	136,712	101.9%	N/A	N/A

Sources: *Annual Report of the Commissioners in Lunacy*, 1890-1909; *Annual Report of the Board of Control*, 1914.

Table 4-3. Admissions of Certified Patients and Voluntary Boarders in the Private Sector, 1890-1914

Year	Certified Patients Admissions	Growth Rate	Voluntary Boarders Admissions	Growth Rate
1890	2,384	N/A	N/A	N/A
1891	2,470	103.6%	243	N/A
1892	2,705	109.5%	273	112.3%
1893	2,639	97.6%	259	94.9%
1894	2,596	98.4%	296	114.3%
1895	2,646	101.9%	344	116.2%
1896	2,452	92.7%	326	94.8%
1897	2,568	104.7%	336	103.1%
1898	2,497	97.2%	280	83.3%
1899	2,481	99.4%	296	105.7%
1900	2,099	84.6%	295	99.7%
1901	2,534	120.7%	273	92.5%
1902	2,586	102.1%	314	115.0%
1903	2,515	97.3%	315	100.3%
1904	2,466	98.1%	307	97.5%
1905	1,996	80.9%	295	96.1%
1906	2,069	103.7%	357	121.0%
1907	1,956	94.5%	355	99.4%
1908	1,932	98.8%	367	103.4%
1909	1,890	97.8%	370	100.8%
1910	N/A	N/A	N/A	N/A
1911	N/A	N/A	N/A	N/A
1912	N/A	N/A	N/A	N/A
1913	N/A	N/A	N/A	N/A
1914	2,065	N/A	422	N/A

Sources: *Annual Report of the Commissioners in Lunacy*, 1890-1909.

By 1914, voluntary admission was thought of as successful by psychiatrists. In 1914, Henry Rayner explained that the public dislike of legal certification brought 'the success of the voluntary boarder system.'[28] The success gave commercial advantages to private mental health institutions. After 1890, many institutions focused on voluntary admission in their advertisements. In the *Medical Directory* in 1890, only 3 of 104 private institutions highlighted a phrase 'voluntary boarders

[28] *Lancet*, February 7, 1914, pp. 420-421.

received without certificate.'[29] In 1914, however, 19 out of 85 institutions employed the copy. As did 35 of 58 in 1930.[30]

The success of voluntary admission relied mainly upon the several eminent registered hospitals for mental diseases, such as the Bethlem Royal Hospital, Manchester Lunatic Hospital and the Holloway Sanatorium. These institutions received between fifty and sixty percent of total voluntary admissions, although they provided only one-third of the accommodations in the private sector.[31] Private asylums, which accommodated approximately two-third of private patients in the sector, were relatively less concerned about voluntary boarders.[32]

The Holloway Sanatorium, a registered hospital under the Lunacy Laws, was one of the most active in receiving voluntary boarders before 1914, as seen in Table 4-4.[33] It, though, decreased its voluntary patients gradually, because of its scandal in 1895 and its managerial strategy for decreasing new admissions to keep high-paying patients.

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[29] *Medical Directory*, London: John Churchill and Sons, 1890, pp. 1742-1764.
[30] *Ibid.*, 1930, pp. 2205-2234.
[31] *The Annual Report of the Commissioners in Lunacy*, 1890-1914.
[32] *Ibid.*
[33] *Ibid.*, 1890, pp. 144-145. In 1890, the Bethlem Royal Hospital received, by comparison, 245 patients and 27 boarders (*Ibid*).

Table 4-4. Admissions of Certified Patients and Voluntary Boarders at the Holloway Sanatorium, 1886-1914

	Certified Patients Admissions	Voluntary Boarders Admissions	Proportion of Voluntary Boarders	Average Number of Certified Patients	Average Number of Voluntary Boarders	Proportion of Voluntary Boarders
1886	162	33	16.9%	N/A	N/A	N/A
1887	95	50	34.5%	141	15	9.6%
1888	108	50	31.6%	169	25	12.9%
1889	169	100	37.2%	N/A	N/A	N/A
1890	193	99	33.9%	261	30	10.3%
1891	156	66	29.7%	318	30	8.6%
1892	175	85	32.7%	330	30	8.3%
1893	202	83	29.1%	347	32	8.4%
1894	176	103	36.9%	354	49	12.2%
1895	122	84	40.8%	341	45	11.7%
1896	137	80	36.9%	343	36	9.5%
1897	184	77	29.5%	366	46	11.2%
1898	174	64	26.9%	381	33	8.0%
1899	162	49	23.2%	377	26	6.5%
1900	129	51	28.3%	363	28	7.2%
1901	123	32	20.6%	362	26	6.7%
1902	121	35	22.4%	366	21	5.4%
1903	104	35	25.2%	367	23	5.9%
1904	123	29	19.1%	366	22	5.7%
1905	100	19	16.0%	353	23	6.1%
1906	124	34	21.5%	361	22	5.7%
1907	117	38	24.5%	350	25	6.7%
1908	127	42	24.9%	351	25	6.6%
1909	121	52	30.1%	355	29	7.6%
1910	143	47	24.7%	360	28	7.2%
1911	103	26	20.2%	362	29	7.4%
1912	122	32	20.8%	359	25	6.5%
1913	120	38	24.1%	365	25	6.4%
1914	132	23	14.8%	368	21	5.4%

Source: 2620/1/1-4 (Surrey History Centre).

2. The Holloway Sanatorium

The Institutional Profile

The Holloway Sanatorium was, a sort of voluntary hospital whose primary purpose was allegedly charitable. Holloway's patron was Thomas Holloway (1800-1883), the manufacturer of patent medicines. After establishing his company, he began

charitable activities. Influenced by Earl Shaftesbury, the Chairman of the Lunacy Commission and an influential legislator for English mental health services, he decided to set up a mental health institution as a part of his philanthropic activities.[34] It was opened at Virginia Water in Surrey in July 1883 in the attendance of the Prince and Princess of Wales.[35]

The Sanatorium was one of Thomas Holloway's major profiles as a philanthropist. For the establishment, he and his relatives spent £ 252,198.[36] At such extraordinary expenses, this institution was designed as the most luxurious mental health institution by W. H. Crossland, the architect of the Holloway College for Women.[37] His design was so-called 'Early English Renaissance.' The main building had a 530 feet principal front, a big dining hall, a grand staircase and recreation hall.[38] The inside decoration included shelves decorated with china, oak dadoes, polished floors, fine furniture, and stained glass. These features led *The Times* to say that expense was 'lavished' on the institution.[39]

Despite this charitable investment, the Holloway Sanatorium did not provide treatment for every patient at charitable rates. This was because it used Holloway's money only for its establishment, and could not collect subscriptions and endowments from the public. As a self-supporting hospital, it depended for 99 percent of the annual income fees from patients.[40]

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[34] *Ibid.*
[35] *Oxford DNB.* Anthony Harrison-Barbet, *Thomas Holloway: Victorian philanthropist a biographical essay*, Egham: Royal Holloway, University of London, 1994, pp. 21-42; Anon., *The story of Thomas Holloway (1800-1883)*, Glasgow: Robert Maclehouse, 1933.
[36] 2620/1/1 (Holloway Sanatorium Papers: Surrey History Centre). The other sources said that the Holloways had spent £ 300,000 on its establishment (Anthony Harrison-Barbet, *op.cit.*; *Times*, June 16, 1885, p. 11). Thomas Holloway's wealth at death was £596,335 8s. 5d (*Oxford DNB*).
[37] 2620/6/22.
[38] *Ibid.*
[39] *Times*, June 16, 1885, p. 11.
[40] The Bethlem Royal Hospital was supported 15 percent of its income by patients (*The Annual Report of the Bethlem Royal Hospital*, 1888-90: Bethlem Royal Hospital Archive).

After Thomas Holloway died in 1883, his family members took over the management of the institution. Three Holloways became trustees of the institution: Mary Ann Driver, his sister-in-law, Henry Driver Holloway (1831-1909),[41] his brother-in-law and Thomas' business partner, and George Martin Holloway (-1895), his brother-in-law and Ann Driver's husband. Among them, Martin and Driver Holloway were the principal trustees from the earlier ages of the institution.[42]

Local dignitaries were also trustees; for instance, Colonel Arthur Brodrick, whose career had been concerned only with military matters and local administration in Surrey, became the trustee in the 1920s.[43] His biographer found no clear link with the Holloways and the mental health services. The increasing local connexion resulted from the regulation of the Sanatorium published in 1886 stating that 'any person resident in Surrey or Berkshire should become a Governor,' a step to becoming a trustee.[44] Because of this regulation, by 1900, about 30 local names joined the Sanatorium as Governors. They were the landed gentry around Surrey, barristers, Members of Parliament in Surrey and Berkshire and Aldermen of the City of London.[45] Their purpose was charitable; to become a Governor, it was stipulated, they should be 'the owner or occupier of land or houses rated to the relief of the poor at not less than £150 per annum in one of the following counties, viz., Middlesex,

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[41] *Times*, April 16, 1909, p. 9.
[42] 2620/1/4. The Trustees of the Holloway Sanatorium were not recorded in the early period (2620/1/1). It is unknown when M. A. Driver gave up her trusteeship. From 1901, Holloway's trusteeship were documented. In its early days, Walpole Greenwell, a stockbroker of Thomas Holloway, the late president of the Royal Shire Horse Society and the former High Sheriff of Surrey was also a trustee. He was a person close both to the Holloway family and to gentleman's community in Surrey and Berkshire (*Times,* October 17, 1919, p. 14; Anthony Harrison-Barbet, *op.cit.*, p. 38).
[43] *Times*, September 24, 1934, p. 17.
[44] 2620/6/9.
[45] *Times*, October 16, 1922, p. 14; *Who was who, 1897-1915*, London, 1935, p. 314; p. 337; p. 423; p. 546.

Surrey, or Berks.'[46] In this way, the Holloway Sanatorium gradually changed its nature from Holloway's charity to a local gentlemen's one.

The Holloway Sanatorium employed five qualified doctors: a medical superintendent, a senior assistant, a second assistant, and two junior assistants. From 1883 to 1897, the medical superintendent was Sutherland Rees Philipps who had previously served as medical superintendent at the Wonford House Hospital in Exeter, a registered hospital for mental disease.[47] Before coming to Exeter, he had been a senior assistant at three county asylums. From 1897, the superintendence was succeeded by William D. Moore, the senior assistant at the Sanatorium.[48] Moore had been medical officer of health in the Alresford District and the senior assistant medical officer at the Wiltshire County Asylum.[49]

Philipps and Moore were known neither in psychiatric politics nor in its academics. Rather, they did not seem to intend to make the institution the frontline of modern psychiatry. Nor did they play an active role in producing scientific knowledge in medical psychology.[50] Their favoured principle of treatment was rest, occupation and amusement, all of which were passive therapeutics.[51]

Admissions and Finance

The Holloway Sanatorium was a successful and unique institution in the late nineteenth-century English mental health services, because, although starting later

[46] 2620/6/9.
[47] *Medical Directory*, 1896, Vol. 2, p. 953.
[48] 2620/1/1.
[49] *Medical Directory*, 1914, Vol. 2, p. 863.
[50] *Ibid.*, 1890-1914; 2620/1/8-9.
[51] 2620/1/1; 2620/1/4.

than other institutions, it instantly began thriving in terms of its admissions and finance.

In 1886, it accommodated 141 patients and 15 boarders on the yearly basis,[52] but in 1898, it speedily increased its total inmates to 414 on yearly average, thereby keeping approximately 350 inmates by 1930.[53] This was because it received many and continuous applications for admissions from prospective patients. As a result, by the 1900s, it came to select patients suitable for the institution, declining most of the charitable applications.[54]

The popularity of the Holloway was partly because it specifically targeted the middle class. As *The Times* pointed out in 1885, English psychiatry provided few institutions for the middle class 'between private asylums for the rich and county asylums for the poor.'[55] For the middle class, the Bethlem Royal Hospital provided care and treatment, but its beds were always full.[56] To fill the gap, Earl Shaftsbury advised Thomas Holloway to initiate the Holloway Sanatorium, and so he did. More importantly, its attractiveness was complemented both by the royal family's attendance at the opening ceremony and by the unusually luxurious facilities. It was not an asylum in a traditional sense.

The popularity brought great financial advantages to the Holloway Sanatorium. With about 350 inmates between 1890 and 1930, it greatly increased its annual income. In 1886 when the annual average number of resident inmates was 156, the institution received £ 12,121 for the care and treatment.[57] In 1906, however,

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[52] 2620/1/1.
[53] 2620/1/9.
[54] 2620/1/4.
[55] *Times*, June 16, 1885, p. 11.
[56] Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker, and Keir Waddington, *op.cit*, pp. 595-602. There was another charitable hospital for mental diseases in London: the St. Luke's Hospital at Old Street.
[57] 2620/1/1.

it drew £ 67,543 from 383 inmates.[58] For two decades, the average annual payment of a patient rose from approximately £ 77 to £ 176. More surprisingly, it reached £ 326 in 1930.[59] As a result, from the 1900s, the Sanatorium annually had surpluses of between £ 6,000 and £ 11,000 and its reserve funds held £ 76,395 in 1914.[60] The reserve money was invested in various stocks and bonds, whose interest rates were usually between 2.5 and 3.5 percent per annum.[61]

3. Holloway Sanatorium and Voluntary Admissions

Voluntary admission was regarded as an important medical provision at the Holloway Sanatorium. Its Annual Reports often highlighted the therapeutic and humanitarian advantages of voluntary admission.[62] Sutherland Rees Philipps stated in 1887 that:

> This system of extending the advantages of the Institution to voluntary boarders is undoubtedly a step in the right direction as regards the treatment of those mentally affected. ... It has some disadvantages, mainly those due to the extra trouble imposed on the staff; but these disadvantages are more than counter-balanced by the great gain to some patients, who would be distressed and worried by the idea that they were certified lunatics, and who would consequently be less likely to make good recoveries.[63]

This is a typical expression when psychiatrists argued about early treatment of mental disorder. In 1889, Phillips made an additional statement that 'to myself, and

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[58] 2620/1/4.
[59] 2620/1/9.
[60] 2620/1/1. Between 1896 and 1930, the Holloway accumulated £ 117,230 in the form of cash, investments and stocks (2620/1/1-2; 2620/1-4-9).
[61] 2620/7/3.
[62] 2620/1/1.
[63] *Ibid.*

to other superintendents of great practical experience, the boarder system seems to be a step in the path of progress. By it careers are saved which would be ruined by certification.'[64]

Philipps opposed to the legal certification that was incorporated in the 1890 Act. Legal certification, he argued, caused 'the person who comes under its provision to be treated as accused of a crime instead of suffering from a disease' and to become a chronic inmate of mental health institutions.[65] Instead, he stressed the therapeutic and humanitarian effects of voluntary admission:

> The advantage of the boarder system is that the patient comes under treatment at an earlier and more curable stage of his disorder. In two out of three cases he goes out well. He has not been deprived of his liberty, and his prospects have not been damaged by the stigma which too often fastened to the certified patient. Finally on leaving the hospital, he will not receive a chilling official notice from the Commissioners in Lunacy that he is no longer looked upon as a lunatic, although he has been so regarded in the past.[66]

In this sense, voluntary admission was a safeguard for patients' health and respectability. Like Philipps, William D. Moore advocated the voluntary boarder system, saying in 1900 that it worked satisfactorily and most of voluntary boarders were willing to remain at the institution even after their recovery.[67]

In this way, the Holloway Sanatorium publicised voluntary admission as a curative and progressive way of psychiatric treatment. However, it did not simply operate the voluntary boarder system for those purposes. Rather, it expected 'some advantage to the Institution,' in Philipps' words. He never clarified what the

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[64] *Ibid.*
[65] *Ibid.*
[66] *Ibid.*
[67] 2620/1/4.

institutional advantage was.[68] The following sections unveil the practical interest of the Holloway Sanatorium in the voluntary boarder system, through a scandal that took place in 1895.

4. The Holloway Sanatorium Scandal in 1895

Apart from the typical discourse of voluntary admission that highlighted its preventive and humanitarian value, the Holloway Sanatorium possibly regarded this admission system as an advantage in attracting patients to, and keeping them, in the institution. It was not written in the institutional records, since the hospital authorities usually avoided referring to matters that were deemed uncharitable. However, in 1895, its lack of charitable interest was disclosed in a scandal, in which it was alleged that the Sanatorium committed ill-treatment on patients, focusing not on charitable treatment but on its finance.

This scandal began with the accidental death of Thomas Weir, an inmate of the Sanatorium. He was 24 years old and had been a patient at the Hoxton House, a private asylum in London, for two years.[69] On July 17 1894, he was admitted to the Holloway whereby it was found necessary to restrain him mechanically, because of his violent behaviour.[70] This treatment was called 'dry pack':

> The apparatus consists of a blanket and five broad leather straps, connected at intervals by loops with two strips of webbing about six feet in length. The patient is laid upon the blanket, which is drawn over him and folded, so as to envelop him tightly from head to foot. He is then laid upon one of the strips of webbing, and the other is brought down the centre of the front of his body,

[68] 2620/1/1.
[69] *Annual Report of the Commissioners in Lunacy*, 1895, p. 118.
[70] *Ibid.*

> and the straps are drawn sufficiently tight to restrain the movement of all his limbs and keep his arms close to his sides. The upper part of the blanket is then sewn back to prevent interference with respiration by the nose and mouth, and the two lower ends of the webbing are tied between the feet.[71] Although he made his escape from the restraint once and was released for short intervals twice a day, he had been restrained continuously till September 30 when he died.[72]

On the cause of Weir's death, the coroner's opinion was ambiguous; while stating that it was caused by exhaustion following 'mania,' he suspected that the hospital did not exercise sufficient supervision.[73] This indecisive view dissatisfied J. G. Weir, the victim's father. He suspected that the Sanatorium had not provided proper treatment for his son, and he appealed to the Commissioners in Lunacy for making a full inquiry.[74] His request was accepted.

The Commissioners ascertained that the medical staff at the Holloway were negligent of their patients. For example, they saw Thomas Weir in dry pack only once a day.[75] From August 1, only two assistants were in charge of the institution, although five doctors were officially appointed.[76] At the date of Weir's death, no medical staff attended the institution.[77] Considering these facts, the Commissioners concluded that:

> The possible serious results of long-continued restraint of an extreme character do not appear to have been recognised, as we think they should have been, and there has, in our judgement, clearly been a deficiency of medical attention both to this case and to patients generally in this Retreat, where the need of medical care and supervision is most urgent.[78]

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[71] *Ibid.*, p. 119; *Truth*, January 24, p. 210.
[72] *Ibid.*
[73] *Annual Report of the Commissioners in Lunacy*, 1895, p. 118.
[74] *Truth*, January 24, p. 210.
[75] *Annual Report of the Commissioners in Lunacy*, 1895, p. 123.
[76] *Ibid.*, p. 119.
[77] *Ibid.*
[78] *Ibid.*, p. 123; *Truth*, January 24, p. 211.

The report seemed final, but it did not convince J. G. Weir. He still believed that the Sanatorium had more serious features in its management to be examined publicly. Weir suspected the Holloway and Lunacy Commissioners of concealing the incident. He was distrustful of them; the institution made arrangements for the burial of his son without communicating with him, and the Commissioners refused to make this report public.[79]

Weir therefore contacted a member of the House of Commons to publicise the alleged incident. The MP referred it to Henry Du Pre Labouchere, the Whig politician and the publisher and editor of the weekly journal *Truth* - a repository of scandals.[80] From 1895, Labouchere and his journal began an intense and yearly criticism of the Sanatorium.[81]

Truth was started by Henry Du Pre Labouchere in 1877 and survived until 1957. It was published on every Thursday at 6 pence.[82] Its editing principle was known as radical, because it disclosed government scandals and those of other public bodies and institutions.[83] Its critical nature, however, was deemed a commercial advantage; *Oxford DNB* stated that *Truth* was 'for many years by far the most successful of personal organs in the press,' and its disclosure of many scandals almost always had a base in fact, because Labouchere could approach people for 'inside information.'[84] Labouchere, a sensationalist journalist, intimidated the

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[79] *Ibid.*

[80] As for Labouchere and his political concerns, see Robert James Hind, *Henry Labouchère and the Empire, 1880-1905*, London: Athlone Press, 1972.

[81] *Truth* published 10 articles on the Holloway Sanatorium scandal in 1895.

[82] *Truth*'s price seems expensive because such popular weekly papers as People and News of the World were priced at 1 penny (*Newspaper Press Directory and Advertiser's Guide*, C. Mitchell and Co., 1895).

[83] According to the *Newspaper Press Directory and Advertiser's Guide* published in 1895, the principle of *Truth* was 'liberal' (*Newspaper Press Directory and Advertiser's Guide*, C. Mitchell and Co., 1895). The *British Medical Journal* was sold at the same price as *Truth*; *The Lancet* was 7 pence.

[84] *Oxford DNB. The Waterloo directory of English Newspapers and Periodicals, 1800-1900* described *Truth* as 'chatty and irreverent style, new society journalism of the 1870s in company with

officials to report the Weir 'scandal' at the Holloway.[85] In doing so, he revealed Holloway's uncharitable and profit-seeking features of the institution.

On February 28, *Truth* presented the case of a married man neglected in the institution. This negligence was found first when his private nurse visited and found him forced physically to be in a bed. This physical restraint went on, whenever the nurse came to the Holloway. Regarding this continuous restraint, Holloway's medical staff explained that he had not had any fits of violence, but later replaced this explanation with another that it was because of 'a large abscess upon his spine.'[86] No abscess was found by the nurse, though. Being suspicious about the Sanatorium, she asked the superintendent to discharge the patient.

When he was discharged, his relatives suspected that the Sanatorium had neglected him; he was 'so weak as to be unable to stand, and on his back there was a huge open bed-sore four inches in diameter...on his thighs were two other sores.'[87] . After the discharge, the Holloway Sanatorium repeatedly embarrassed this family, by billing extra charges of 49 pounds and 6 shillings - 8 guineas a weak - far beyond the average charge of 2 guineas at the institution. This extra charge was, Ree Philipps explained, due to the employment of a special attendant to the patient. The family and nurse did not believe Philipps' explanation, but Philipps continued to charge them for nine months, insisting that the discharge was 'leave.'[88] This persistent demand was called 'the threat' by Labouchere.[89]

Thomas Gibson Bowes' *Vanity Fair* and Edmund Yate's *World,* and the characteristic was a weekly diet of clever gossip about the aristocratic and fashionable, witty reviews exposing financial scandals and serious political commentaries.' (John S. North (ed.), *The Waterloo directory of English newspapers and periodicals, 1800-1900*, North Waterloo Academic Press, 1997).

[85] Not only did he campaign in *Truth*, Labouchere brought Weir's case into the House of Commons, asking the Minister of the Home Office whether the ministry would have further inquiries on the case (*Parliamentary Debates, House of Commons*, Vol. 30, 1895, pp. 748-749).

[86] *Truth*, February 28, p. 523.

[87] *Ibid.*

[88] *Ibid.*, p. 524.

[89] *Ibid.*.

Such a story was not unique at the Holloway. Labouchere told another story of negligence in 1893. A hint of ill-treatment was felt first by a man who visited his wife who was detained there. During the visit, Holloway's doctors refused him permission to meet his wife, because she attempted to escape and was bruised and bleeding from the result of violence. The husband tried to make a further request to meet her. However, William D. Moore, the assistant medical officer, wrote to him that 'if he liked to give a small donation to the Pension Fund the staff would probably not object to the trouble.'[90] The husband could not understand what the 'trouble' meant, but paid 1 pound 1 shilling to meet his wife. In meeting her, he found that she was confined in the room which was 'a cell in size, construction and appearance,' and furnished poorly with a chair and a camp bed with a mattress, and her left foot still left cut badly.[91] Observing this, the husband arrived at the conclusion that his wife had been ill treated by doctors and this was why he was refused permission to meet her.

These cases are only some of *Truth*'s disclosures. It provided more examples in which patients were asked for unusually high payments and were provided with improper care. The result of the improper care ranged widely from scalding in a bath to suicides. Among these disclosures, the most extreme example was the 'dry pack' found in Weir's case.

Holloway's ill-treatment and negligence were, *Truth* concluded, based on an institutional management scheme to save expenditure. This view does not seem groundless; Holloway's institutional records contribute to evidence. In 1893, Philipps wrote:

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[90] *Ibid.*, p. 525.
[91] *Ibid.*, p. 524.

> The large number of fresh cases which came under care (a number second only to those admitted to Bethlehem Hospital) would gladden the heart of the pious founder, who held strong views on the undesirability of admitting or keeping incurable cases at low rates of payment. Speaking for the medical and nursing staffs, I would express my earnest hope that incurable cases will not be allowed to occupy beds which can be more worthily and usefully filled. There is no doubt good reason for retaining a high-paying chronic cases of unobjectionable habits, as the profit made is available for the keep of two or more curable cases, but there can be no good reason, on humanitarian or utilitarian grounds, for admission on the charitable side of the Hospital of an incurable dement who would be just as happy, and from a classification point of view, better off in a county asylum.[92]

The Holloway was concerned primarily about its finance, focusing on high-paying patients.

This admission policy, it may be argued, promoted the 'early treatment,' because the profit from high-paying patients could be used for treatment of curable incipient cases at charitable rates. But this is not the whole story. Between 1886 and 1930, the Holloway Sanatorium gradually decreased its admissions from 162 in 1886 to 41 in 1930.[93] By the early 1900s, it stopped receiving free admissions. This change, William D. Moore explained in 1902, was because the institution could not find proper cases 'where the social status was sufficient, and where there was a reasonable hope of recovery or amelioration.'[94] However, by giving up charity, the institution earned a surplus of £ 9,400 in that year. Obviously, the Holloway Sanatorium concentrated on accumulating high-paying patients rather than on curing patients charitably in the early stage. As *Truth* alleged, the Holloway Sanatorium was a profit-making psychiatric institution.

In contrast to *Truth*, other popular and medical media reported little on the Holloway Sanatorium's 'scandalous' management. *The Times*, the *British Medical*

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[92] 2620/1/1.
[93] 2620/1/9.
[94] 2620/1/4.

Journal and *The Lancet* reported only the outline of Weir's case.[95] Nor did they ask for further inquiries. Rather, some medical critics were sympathetic to the Sanatorium's authorities. Charles Mercier sent letters to the medical journals, in which he protested against 'an extremely violent attack made by several newspapers' on the institution.[96] He stated that psychiatrists:

> deserve and should be able to rely on public cooperation and support in their difficult and delicate work, and we regret and deprecate extremely the gruesome language which many modern journalists allow themselves to employ when speaking of useful institutions and of the physicians in charge of them.[97]

He concluded that the writing about Weir's case was 'groundless.'

While the medical commentaries disregarded the Holloway Sanatorium scandal, however, the Weir's case was taken to the Home Office. In its inquiry, it was ascertained that the institution did not provide sufficient medical staff and treatment, thereby seeking profit. William Court Gully (1835-1909), a barrister and MP in charge of the Home Office's Inquiry on the Thomas Weir's case, reported:[98]

> Weir's case was at the time of this restraint the most acute in the hospital, and was being treated by a course of restraint more severe than had ever been administered in the hospital to any other patient. It required more continuous attendance and medical observation than that of any other inmate. It is, therefore, impossible to avoid the conclusions that at the time in question, not only was there *an insufficient medical staff, but there was a total absence of that systematic watchfulness, discipline, and supervision which are absolutely necessary in a great hospital for the insane*, and that these

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[95] *Lancet*, July 20, 1895, p.174; *Ibid.*, August 24, 1895; *Times*, March 13, 1895, p. 8.
[96] *Lancet*, April 20, 1895, p. 1003.
[97] *Ibid.* In the *British Medical Journal*, Mercier tried to 'secure for those of our number who have been so cruelly and outrageously attacked the sympathy and the moral support of the members of the profession.' (*British Medical Journal*, April 13, 1895, p. 843).
[98] Gully was connected politically with Labouchere, since Labouchere introduced Gully to Henry Campbell-Bannerman who looked for a candidate for the speaker of the House of Commons in 1895 (*DNB*).

> deficiencies largely contributed to cause the death of Thomas Weir [Italic: Labouchere's].[99]

Furthermore, Gully criticised Philipps, saying that 'he did not consider himself in active medical charge of the establishment, but looked upon himself more as the consultant physician.'[100] This was crucial because Gully described the superintendent of the charitable hospital as a doctor working for his private practices.

Through the 1895 scandal, the Holloway Sanatorium was represented as an non-charitable institution that neglected patients for the financial reason, and its medical staff as malicious doctors who profited privately behind a facade of the charitable institution. It was in this context that the Holloway Sanatorium manipulated voluntary admission for its institutional survival.

5. Voluntary Admissions as a Means of Institutional Management

In the 1895 scandal, *Truth* argued that the Holloway Sanatorium used voluntary admissions as a means to make money. The institution, Labouchere claimed, deliberately transferred voluntary boarders to certified lunatic status. He explained:

> The Sanatorium proper is 'a pay-hospital for nervous invalids, and patients go there voluntarily for treatment who are in no sense of the word lunatics. The treatment, however, may not be successful. The patient may become worse-many of them do. "Nervous disorder" may develop into mental derangement-it very often does. In such a case the patient has to be treated as a lunatic, and placed under restraint. For that purpose he ought to be officially certified as a lunatic under the Acts. The formalities in connection with the obtaining of the certificate are, in such a case, gone through by the Sanatorium authorities. They are, of course, the same as those which have to

[99] *Truth*, December 12, 1895, pp. 1522-1523.
[100] *Ibid.*, September 12, 1895, p. 613.

> be gone through in the case of any other person certified for the first time as a lunatic, and placed under restraint. ... Many patients appear to have been transferred in this way at the Holloway Sanatorium, and no one, I think, who appreciates the position will regard such an arrangement as desirable.[101]

Such transfers, Labouchere argued, were conducted by the hospital authorities intentionally and systematically. When Holloway's doctors discovered indications of insanity in the symptom of voluntary patients, they readily arrived at 'the conclusion that the boarder should become a permanent and involuntary resident. They not only raise this question, but they decide it-or, at any rate, they can do so, and have done in innumerable cases.'[102] Thus, the Holloway invented a system of quick transfer of voluntary patients to involuntary status.

Labouchere revealed this system, by referring to an inside story of an unusual inmate of the Holloway, a medical man who was admitted in the early 1890s. He suffered from melancholia and delusions, but recovered at the end of a few months. However, he continued to stay at the institution as a voluntary boarder, an extraordinary course at a mental health institution.

Labouchere disclosed that during this man's extra-stay, the institution asked him to sign certificates of other boarders to make them certified lunatics.[103] The 'ex-lunatic' doctor signed no less than 25 such certificates. This irregular management was an 'abuse' of the Lunacy Acts, Labouchere claimed, vouching for his sources. The Commissioners in Lunacy confirmed in its later investigation that 25 boarders were indeed certified by the ex-lunatic doctor.[104]

This certification of voluntary patients was cunning, because in doing so, the Holloway avoided breaching the regulation of the Lunacy Act of 1890 that a lunacy

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[101] *Truth*, March 7, 1895, p. 587.
[102] *Ibid.*, September 12, 1895, p. 612.
[103] *Ibid.*
[104] *Annual Report of the Commissioners in Lunacy*, 1896, p. 42.

certificate should be signed by a doctor who was not the staff of the institution receiving the patient, and did not have any financial interest in the institution. Holloway thus cleverly evaded statutory requirements that prevented institutions from certifying patients for any financial reasons, since the ex-lunatic doctor was not interested in financially, nor the hospital staff. Discovering this new trade of lunacy, Labouchere warned the public against the dangers to liberty of British subjects.

To carry on the transfer of voluntary boarders, the Holloway Sanatorium accommodated those who were, in fact, certifiable cases. In 1896, the Lunacy Commissioners stated that they found 'too frequently' that persons residing as boarders at the institution were indeed certifiable and felt obliged to require that such boarders be either removed or certified as lunatics.[105] At the Holloway, the Commissioners thought, voluntary boarders were accommodated as reserves for certified patients.

The transferring procedure had been initiated by Holloway's staff. They produced petitions for lunacy certification of voluntary boarders, Labouchere revealed, although the 1890 Act required that this procedure be principally taken by the patient's relatives. Again, Labouchere's allegation was confirmed by the Lunacy Commissioners.[106] Thus, the Holloway Sanatorium operated an institutional machinery to keep patients for a period longer than necessary, whether the initial admissions were voluntary or compulsory.

Exploiting the Lunacy Laws, Holloway achieved the best rate of certifying voluntary boarders in England and Wales in the early 1890s. Table 4-5 shows that it transferred 108 of its 337 boarders into certified lunatic status between 1891 and 1894. Even if this is compared to two other registered hospitals that received many

[105] *Ibid.*, pp. 42-43.
[106] *Truth*, September 12, 1895, p. 612; *Ibid.*, December 12, 1895, p. 1523.

boarders, it is obvious that the Holloway had transferred an extraordinary number of boarders to certified lunatic status.

Table 4-5. Certification of Voluntary Boarders at Selected Mental Health Institutions, 1891-1894

	1891			1892			1893		
	Voluntary Boarders admission	Boarders later certified	Rate	Voluntary Boarders admission	Boarders later certified	Rate	Voluntary Boarders admission	Boarders later certified	Rate
Holloway Sanatorium	66	22	33.3%	85	32	37.6%	83	36	43.4%
Manchester Lunatic Hospital	42	4	9.5%	43	20	46.5%	43	16	37.2%
Bethlem Royal Hospital	45	13	28.9%	42	8	19.0%	43	17	39.5%
Registered Hospitals	168	44	26.2%	180	63	35.0%	189	75	39.7%
Private Asylums	75	18	24.0%	93	20	21.5%	70	14	20.0%
Total	243	62	25.5%	273	83	30.4%	259	89	34.4%

	1894			1891-1894		
	Voluntary Boarders admission	Boarders later certified	Rate	Voluntary Boarders admission	Boarders later certified	Rate
Holloway Sanatorium	103	18	17.5%	337	108	32.0%
Manchester Lunatic Hospital	45	14	31.1%	173	54	31.2%
Bethlem Royal Hospital	42	15	35.7%	172	53	30.8%
Registered Hospitals	204	51	25.0%	741	233	31.4%
Private Asylums	92	17	18.5%	330	69	20.9%
Total	296	68	23.0%	1071	302	28.2%

Source: *Annual Report of the Commissioners in Lunacy*, 1891-1894.

In running the institutional machinery of certifying boarders, Labouchere explained, the Holloway Sanatorium intended to save the fees applied to an outside practitioner for lunacy certification.[107] This allegation, however, was denied by the Commissioners in Lunacy. They remarked that the institution simply wished 'to

[107] *Ibid.*, September 19, 1895, p. 677.

confer some pecuniary benefit' on the ex-lunatic doctor himself.[108] However, the institutional record of the Holloway Sanatorium shows that it often manifested its financial interests in admitting voluntary boarders. This is observed in the charitable activities of the Holloway Sanatorium. By the recommendation of the Charity Commission that was legislated in the Charitable Trusts Acts, 1853, the Holloway was required to admit a certain number of patients at discounted charges. Such a requirement was called 'the charity scheme.' The first charity scheme was enforced on June 29 in 1889.[109] Its most important item was that:

> Not less than one-half of the total number of patients for the time being in the Hospital shall be admitted at a charge not exceeding £2. 2s. a week, to cover entire cost of maintenance and medical treatment, and of the number of patients so admitted not less than one-half (being not less than one-fourth of the total number of patients) shall be admitted at a similarly inclusive charge of £1. 5s. a week.[110]

This practically suggested that among 341, 85 patients be treated at less than 1 pound and 5 shillings a week (Class 1), and 170 patients be at the rates not exceeding 2 pounds and 2 shilling a week (Class 2). Hence, the high-paying patients should not exceed 86 (Class 3).[111]

Through voluntary admissions, the Holloway Sanatorium intended to extend its capacity to receive high-paying patients. In 1889, the medical superintendent, Philipps, sent a letter to the Charity Commissioners to confirm that the word 'patients' in the charity scheme excluded 'voluntary boarders.' He also stated that he worried about whether the scheme contained 'any provision which would

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[108] *Annual Report of the Commissioners in Lunacy*, 1896, p. 42.
[109] 2620/6/6.
[110] *Ibid.*
[111] 2620/1/1.

interfere with the reception of boarders into the Sanatorium.'[112] This was overruled by the Charity Commissioner, who said that 'patients' included 'all inmates of the Sanatorium.'[113] In these correspondences, Philipps seemed to use voluntary admission commercially rather than charitably; in other related correspondences, Holloway's users often complained that it did not follow the charity scheme.

In 1895, J.G. Weir, the father of Thomas Weir, sent a letter to the Charity Commissioners, in which he alleged that the Holloway Sanatorium evaded its charity scheme. According to him, his son was to be admitted at 2 pounds and 2 shillings per week (Class 2).[114] Nine days after the admission, however, Philipps demanded 68 pounds and 5 shillings, which meant the payment of £ 5 a week, because Thomas required so much attention. This extraordinary expense was demanded up to the day prior to Thomas Weir's death.[115] Weir asked the Charity Commissioners whether such a persistent demand was not 'a breach of the covenants' of the original charity scheme. The Charity Commissioners denied Weir's allegation.[116]

Weir's was not an isolated case. In 1898, the sister of Holloway's patient, Charles Booker Brown, complained that although she had succeeded in petitioning the Charity Fund to admit her brother into the Holloway Sanatorium at the rate of 1 pound and 5 shillings, Philipps sent the brother to the Gloucester County Asylum without her consent.[117] Such cases would suggest that the Holloway Sanatorium did not abide by the charity scheme. Throughout the late nineteenth and early twentieth centuries, it steadily decreased its charitable admissions. Table 4-6 covers the years

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[112] *Ibid.*
[113] 2620/6/3.
[114] *Ibid.* In the original agreement, J. G. Weir was to pay 27 pounds and 6 shillings quarterly.
[115] *Ibid.*
[116] *Ibid.*
[117] 2620/6/6.

when Thomas Weir and Charles Booker Brown were admitted. In 1894, while it was inclined to admit high-paying patients, the Holloway Sanatorium still obeyed the charity scheme. In 1898, however, it did not. Weir and Brown were excluded from the Sanatorium because they represented unprofitable payment. In relation to the charity scheme, the Holloway Sanatorium was concerned exclusively about profit-making. Considering Philipps' correspondence, voluntary admission was not an exception.[118]

Table 4-6. The Distribution of Patients' Payments at the Holloway Sanatorium, 1894 and 1898

		Class 1 (weekly payment should be less than 25s)	Class 2 (weekly payment should be between 26 and 42s)	Class 3 (weekly payment can be over 42s)	Total
1894	Admissions	42	92	86	220
		19.1%	41.8%	39.1%	
	Inmates on December 31	160	155	100	415
		38.6%	37.3%	24.1%	
1898	Admissions	8	106	85	199
		4.0%	53.3%	42.7%	
	Inmates on December 31	81	183	119	383
		21.1%	47.8%	31.1%	

Source: 2620/2/ (Surrey History Centre).

Why did the Holloway Sanatorium so desperately need money? Labouchere suspected that its doctors and governors appropriated profits for their own; among the total profit of £ 9,233 in 1893, £ 2,177 was not accounted for.[119] Labouchere also referred to the surplus of £ 1,556 in 1894 whose destination was not

[118] The Holloway Sanatorium did not keep clinical and admission records of voluntary boarders before 1897 (3473/3/33).
[119] *Truth*, September 12, 1895, p. 613.

specified.[120] He expected this speculation to fill the gap in the *Truth*'s story. However, the Lunacy Commissioners denied Labouchere's allegation, saying that *Truth* only examined an abstract of Holloway's accounts which appeared in the *Annual Report* of the Lunacy Commissioners. The accounts annually kept by the institution specified the profit properly.[121] This is correct; it specified in its annual reports how the annual profit was used.[122] Most of the annual surpluses were invested in various bonds and stocks in individual names of trustees.[123]

The profit-making management of the Holloway Sanatorium was rooted in its institutional character. Because it started later than other mental institutions, it did not have any specific sources of subscriptions and endowments after having spent Thomas Holloway's legacies on the establishment. Thus, the hospital governors were always worried about its resources. In 1901, the House Committee remarked in the annual report that:

> It is to be observed that the increase n maintenance account was due to the fact that there were in 1901 more of the richer class of patients, and that consequently the Committee felt justified in relieving a larger number of necessitous patients. This illustrates the importance, in the absence of endowment, of having a number of richer patients in order to secure funds for the maintenance of those who, though of suitable social status, could not afford the necessary expense.[124]

The Holloway Sanatorium, even though being a charitable institution, was anxious for its future. If it failed to make surpluses, it would face closure. For psychiatrists, it meant unemployment. Hence, they became collaborators in the unlawful trade of lunacy.

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[120] *Ibid.*
[121] *Annual Report of the Commissioners in Lunacy*, 1896, pp. 43-44.
[122] 2620/1/1.
[123] *Ibid.*
[124] *Ibid.*

Conclusion: Voluntary Admission Outside the Holloway

In examining the institutional management of voluntary admissions to mental institutions, this chapter has argued that the Holloway Sanatorium used voluntary admission for its institutional survival under the 1890 Act. Psychiatrists usually described voluntary admission as a progressive system that provided therapeutic benefit and humanitarian care for patients, its less legalistic nature encouraging patients to visit mental health institutions at an early stage of their illness. Reiterating this idea, the Holloway Sanatorium promoted voluntary admissions, but failed to provide any therapeutics. Rather, its purpose was to keep 'high-paying' patients in order to make money. To do so, it invented special machinery to transfer voluntary patients into compulsory detained ones. Such a project was only a detail of Holloway's strategies to raise money.

Following the Holloway Sanatorium scandal, the Commissioners in Lunacy reinforced the administrative regulation of the voluntary admissions system. From 1895, the managers of private institutions under the Lunacy Laws had to submit a notice of reception of boarders to the Commissioners within twenty-four hours, or suffer a penalty of five pounds a day. They were also required to keep a proper register of voluntary boarders. These new regulations, however, seem not to have decreased the instrumental value of voluntary admission to the institutional management.

In other private institutions, voluntary admission seemed to have been used similarly. The *Annual Report* of the Lunacy Commissioners published in 1895 stated that two private asylums retained certifiable persons as voluntary boarders:

Haydock Lodge in Lancaster, and Tue Brook Villa at Liverpool.[125] Both were thriving provincial private asylums. In other private asylums, the voluntary admission system might be used properly. For example, at Malling Place, voluntary boarders were not certified in most cases, and were discharged in a relatively short period.[126] This is perhaps because it had many local general practitioners who regularly recruited patients to the institution, so that it did not have to resort to voluntary admissions for financial reasons.[127]

The certification of voluntary boarders continued to be a useful but irregular means to finance such private institutions. In the 1920s, it again surfaced in a scandal disclosed by the National Society for Lunacy Reform and Sara Elizabeth White (1855-1938), a radical female doctor critical of the private asylum business.[128] This story is dealt with in Chapter 6.

Psychiatrists anticipated the misuse of voluntary admission. Even although acknowledging the potential mismanagement, they promoted the admission system. George H. Savage referred to the voluntary admission system in 1887, saying that:

> The voluntary admission may lead to abuses of the worst kind..., the entrapping patient to asylums as free persons and then certifying them as lunatics.[129]

But he changed his opinion after 1890, thereby advocating the system in 1891, as seen in the above discussion with Clifford Allbutt. Conducting a secret commission

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[125] *Annual Report of the Commissioners in Lunacy*, 1896, pp. 54-55.
[126] MC3 (Centre for Kentish Studies).
[127] Ap1; AP3. John A. Glover, H.J.M. Pope and H.H. Fisher, all of who were local practitioners, appeared in the admission register very often in the late and early twentieth centuries.
[128] Sara Elizabeth White was born and later practiced at Armagh in Ireland. She was educated at the University College Hospital and London School for Women, and later experienced junior doctor's position in the latter school. After finishing it, she was back to her born place and had general practice (*Lancet*, February 26, 1938, p. 521). The editors of *Englishwoman* in 1920 were Frances Balfour, Mary Lowndes, Edith Palliser and J. M. Strachey.
[129] *Annual Report of the Commissioners in Lunacy*, 1887, p. 38.

through voluntary admission, psychiatrists secured their working places that were jeopardised by the legalistic legislation of 1890.

Chapter Five. The Political Economy of the Psychiatric Profession and the Great War

Introduction: Shell Shock and English Psychiatry

In 1919, *The Lancet* claimed that one-third of unwounded discharges from the Great War, or one-seventh of the total discharges, were the victims of shell shock.[1] *The Report of the War Office Committee of Enquiry into "Shell-Shock"* published in 1922, recorded that 65,000 ex-soldiers received pensions for 'psychiatric disability.'[2] These enormous psychiatric casualties were not merely a temporary military and pension issue; they also considerably changed the political and economic landscape of early twentieth-century psychiatry.

Shell shock has attracted enormous attention from historians of psychiatry. Earlier work has argued that Freudian psychoanalysis came into its own through the treatment of shell shock.[3] Subsequent studies have tended to emphasise, instead, the relative continuity of English psychiatric theories and practices.[4] According to historian, Sonu Shamdasani, for instance, the war and post-war periods reveals, not the prevalence of psychoanalysis, but mixed and freely defined psychotherapeutics.[5] Other historians have looked into historical aspects of shell shock, such as the post-

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[1] *Lancet*, April 12, 1919, p. 619.
[2] *Report of the War Office Committee of Enquiry into "Shell-Shock,"* London: H.M.S.O., 1922, p. 189.
[3] Eric J Leed, *op.cit.*, 1979; Elain 犬 Showalter, *op.cit.*, 1985; Martin Stone, *op.cit.*, 1985, pp. 242-271.
[4] Peter Jeremy Leese, *op.cit.*, 2002; Ben Shephard *op.cit.*, 2000.
[5] Sonu Shamdasani, 'Psychotherapy': the invention of a word,' *History of the Human Sciences*, Vol. 18, 2005, pp. 1-22.

war controversy over cowardice,[6] the political neglect of shell-shocked patients,[7] and the impact of this medical event on the interwar culture.[8] Histories of shell shock from a comparative perspective have provided long-term analyses of military medicine and PTSD history.[9] Also, Gender studies have somehow etched their place; for instance, Elaine Showalter alleged that shell shock shifted the cultural representation of mental diseases from a female disease to a male one.[10]

All this attention tends to overlook the impact of shell shock upon the politics of the psychiatric profession expressed in relation to mental health legislation and the market in mental health. In this respect, only Clive Unsworth has contributed, arguing that Lloyd George's project of 'war reconstruction' affected the political reform of lunacy legislation. Unsworth overlooked, however, that shell shock itself brought a significant impact on psychiatric politics – once again – in relation to the 'early treatment of mental disorder,' and on the mental health market.

During the war, many parliamentary members and local asylum authorities objected to the detention of shell-shocked soldiers in lunatic asylums, and demanded non-asylum, non-certifying and non-pauperising treatment for them. Following this demand, the government established a special arrangement whereby shell shocked soldiers would be treated separately from those under the Lunacy Act of 1890. For English psychiatrists, this was the long-awaited public support for their claim for the

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[6] Anthony Babington, *Shell-shock: a history of the changing attitudes to war neurosis*, London: Leo Cooper, 1997; Ted Bogacz, 'War Neurosis and Cultural Change in England, 1914-22: The work of the War Office Committee of enquiry into "shell-shock",' *Journal of Contemporary History*, Vol. 24, No.2, 1989, pp. 227-256; Gerard Oram, *Worthless men: race, eugenics and the death penalty in the British Army during the First World War*, London: Francis Boutle, 1998; Gerard Oram, *Death sentences passed by military courts of the British Army, 1914-1924*, London: Francis Boutle, 1998.
[7] Peter Barham, *op.cit.*, 2004.
[8] Jay Winter, *op.cit.*, 2000, pp. 7-11.
[9] Mark S. Micale and Paul Lerner (eds), *op.cit.*, 2001; Allan Young, *The harmony of illusions: inventing post-traumatic stress disorder*, Princeton: Princeton University Press, 1997; Wendy Holden, *Shell shock*, London: Channel 4, 2001; Hans Binneveld, *From shell shock to combat stress: a comparative history of military psychiatry*, Amsterdam: Amsterdam University Press, 1997.
[10] Elain Showalter, *op.cit.*

'early treatment of mental disorder.' This chapter argues that shell shock gave the psychiatric profession new legitimacy for its politico-economic claims. However, if the war was good for psychiatry in this respect, it at the some time introduced a new medical specialism of neurology to the interwar market of mental disease. Throughout, the chapter reinterprets the wartime political economy of English psychiatry through emphasising historical continuity.

1. Shell Shock in Parliament

A key to understanding the political and economic history of English psychiatry in the Great War was the intense public opposition to the detention of shell-shocked soldiers in lunatic asylums, which was represented by parliamentary members and local authorities. From late 1914, shell-shocked soldiers, including cases of nervous and mental disorders, were dealt with at military hospitals, but some of them were transferred to and detained at lunatic asylums.

In the early stage of the war, the government regarded this issue as unproblematic, but unexpectedly, a number of politicians began claiming that shell-shocked soldiers should not be detained in lunatic asylums. This parliamentary opposition began in February in 1915. James Duncan Millar (1871-1932), a Liberal MP from North East Lancashire and a barrister, asked the War Office whether mentally wounded soldiers were to be treated in lunatic asylums and:

> Whether steps had been taken to secure that the treatment of soldiers and sailors suffering from mental strain should be carried out in hospital wards or

> other institutions not under lunacy administration, so as to avoid sending all such cases, which were not certifiable, to asylums.[11]

Responding to Millar, the Under-Secretary of the War Office stated that his ministry endeavoured to treat them in 'private and civil hospitals' to avoid sending them into lunatic asylums. From then until the end of the war, 38 politicians reiterated Millar's question 72 times. In wartime, they showed unusually intensive attention to psychiatry. The reason for this was that asylum detention would degrade the social respectability of the shell-shocked. Five days after his first action, Millar again argued to the Committee of Army Estimates that:

> These cases [shell shock cases] ought never to be associated with the treatment of the ordinary lunatic, as in most, if not almost in every case, there is a chance of complete restoration to health again, and no stigma of insanity ought to attach to them.[12]

In his understanding, the lunatic asylum was not a site of treatment, but of humiliation.

Not only did Millar oppose the asylum incarceration of shell-shocked soldiers, but he also refused any dealing with the lunacy administration. He insisted that the visitation of Lunacy Commissioners should not be done for those soldiers, because it would impose the impression upon them and the public that they were 'insane' and therefore under lunacy administration. This was an unusual statement, since the Lunacy Commissioners served the public good of safeguarding the ill-treatment and wrongful confinement of English citizens in asylums.

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[11] *Parliamentary Debates, House of Commons*, Vol. 69, 1915, p.146.
[12] *Ibid*, p. 515.

Millar was not the only one to pose such questions. Athelstan Rendall (1871-1948), a Liberal MP from Gloucestershire, also resisted asylum treatment of shell-shocked soldiers. In June 1915, he asked:

> Whether he [the Under-Secretary of State for War] will consider the possibility, as an alternative, of treating transiently acute cases of nerve shock in the same way as delirious cases are treated on medical lines in ordinary hospitals, and so save both the injured soldiers and their families from the opprobrium associated with having been treated in a lunatic asylum?[13]

In reply, the Under-Secretary of State for the War Office said that doctors who dealt with shell-shocked patients were 'specialists in nervous diseases, not psychiatrists.'[14] The War Office, though, did not actually exclude asylum doctors from the treatment.

To improve the provision for shell-shocked soldiers, some politicians suggested non-asylum treatment without legal intervention. George Alexander Touche (1861-1935), a Unionist MP from Islington, proposed that hospital treatment, apart from the lunacy administration, be provided for shell-shocked soldiers.[15] The grounds were the social prejudices against asylum inmates. Charles William Bowerman (1851-1947), a Labour MP from Deptford, insisted on the necessity for 'encouraging county or borough councils to establish homes or hospitals for the early treatment of nervous breakdown, separate from lunacy administration.'[16] The early treatment of mild mental diseases again appeared in politics, caused not by psychiatrists but by non-medical politicians.

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[13] *Ibid*, Vol. 72,1915, p. 494.
[14] *Ibid.*
[15] *Ibid*, Vol. 74, 1915, p. 332; *Ibid*, p. 1019.
[16] *Ibid*, Vol. 70, 1915, p. 816.

Facing the new political demands, Cecil Harmsworth (1869-1948), the Parliamentary Secretary to the Home Office, introduced an amendment bill to the Lunacy Act of 1890 in the House of Commons. Its main purpose was 'to facilitate the early treatment of mental disorder of recent origin arising from wounds, shock, and other causes,' and to enable the soldiers disabled by nerve strain 'to be placed for six months under care and treatment in an institution intended for the insane.'[17] The 1915 bill was expected to meet the political demands for less legalistic provisions for shell-shocked soldiers, but as usual, in Parliament, it was withdrawn because politicians still worried that the bill would jeopardise the current legal safeguard for the liberty of the English subject.[18] To meet the political request for securing 'suitable treatment of cases of nerve strain without compulsory detention,' it was argued, the War Office should provide a non-legislative and original service for the shell-shocked soldiers.

2. The Mechanism of Political Relief for Shell-Shocked Soldiers

Hospital Treatment for War Heroes

There were four kinds of political concerns behind politicians' demands for the non-asylum and non-certifying treatment of shell-shocked soldiers. Some politicians

[17] *Ibid*, Vol. 71, 1915, p. 1816.

[18] Athelstan Rendall, a Liberal MP, opposed to the 1915 bill, pointing out that 'there is no provision in the Bill for any appeal to a magistrate.' In doing so, he posed a question: 'will he [under-secretary to the War Ofice] undertake to propose or accept an Amendment whereby the ordinary safeguards extended hitherto to all British subjects protecting them from unjust treatment may be made equally applicable for the protection of soldiers?' (*Ibid*). Following this question, Cecil Harmsworth, who had introduced the bill, replied that any legislative arrangement for shell-shocked soldiers might not be necessary (*Ibid*).

stressed the state responsibility to provide proper welfare services for soldiers and sailors - 'war heroes.' In October 1915, George Alexander Touche proposed a provision of hospital treatment for 'uncertifiable' mental soldiers to 'protect them from the risk of the detriment which is likely to result in respect of the men's industrial future.'[19] To justify this idea, he cited the report of the Local Government Board's Committee on Employment for Soldiers and Sailors Disabled in the War, the so-called Murray Commission, which concluded that the state was responsible for the best care of war heroes. Josiah Clement Wedgwood (1872-1943), a major in the Army and a Liberal MP from Newcastle-under-Lyme, also thought it important to enable shell-shocked soldiers to 'go voluntarily for the medical care they need and to find cheerful surroundings, with employment of such a nature as may expedite their return to the line of self-supporting citizens.'[20] The treatment of shell shock was a part of the state project of rehabilitation of soldiers into society.

Military Members of Parliament similarly had interests in the governmental provision for the shell-shocked. Wedgwood stressed the importance of defending the respectability of soldiers serving the nation.[21] Colonel Charles Yate (1849-1940), a famous Army officer for the service in Afghanistan in the 1880s, asked the War Office for a special measure to allow shell-shocked soldiers to do light work and to be employed in agriculture, gardening and cultivation. The purpose of these advocates was to afford soldiers 'some relief from the monotony of their existence and give them an interest in life.'[22]

Not only in Parliament, but also in popular representations, shell-shocked soldiers were 'war heroes,' not 'cowards.' In the *Daily Graphic*, an anonymous

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[19] *Ibid*, Vol. 75, 1915, pp. 11-12.
[20] *Ibid*, Vol. 85, 1916, p. 1259.
[21] *Ibid.*, pp. 881-882.
[22] *Ibid*, Vol. 94, 1917.

contributor contended that proper hostels should be provided for 'heroes mentally wounded,' since such 'soldiers who had served our country were put, here in England, into worse prisons [lunatic asylums] than our prisoners in Germany.'[23] This was an application of the idea of 'homes fit for heroes' to shell shock.[24] Soldiers serving in the nation's crisis should be entitled to proper welfare that would not ruin their social life.[25]

Saving the Working-Class from Lunacy Incarceration

Parliamentary politicians argued that shell shock was a social problem, because it led working-class soldiers, who had maintained themselves, to become destitute pauper lunatics.[26] This concern arose mainly from Labour politicians. They were more interested in shell shock than the other parties. While five percent of the other parties' politicians referred to shell shock in wartime, twenty percent of the Labour members raised the matter.

To appease their constituencies, Labour politicians demanded special governmental provision and subsidies for shell-shocked soldiers and their families. In November 1916, William Crawford Anderson (1877-1919), a Labour MP and the organizer of the National Union of Shop Assistants, asked the Financial Secretary to the War Office whether family members of shell-shocked soldiers should be

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[23] *Journal of Mental Science*, July 1917, pp. 450-454.
[24] As for 'homes fit for heroes,' see Mark Swenarton, *Homes fit for heroes: the politics and architecture of early state housing in Britain*, London: Heinemann Educational Books, 1981.
[25] The sympathetic attitude of parliamentary members towards the shell shocked is possibly understood as similar to John Hutchinson's thesis that wartime medicine's humanitarianism was an important part of the war machinery with which to efficiently recycle the wounded back in to the front (John F. Hutchinson, *Champions of charity: war and the rise of the Red Cross*, Boulder: Westview Press, 1996).
[26] Peter Leese argues that parliamentary questions about shell shock show how military officers were privileged (Peter Leese, *op.cit.*, p. 59).

responsible for their maintenance when the soldiers were detained in lunatic asylums and classified as pauper lunatics, and 'whether, in the case of a married soldier, the separation allowance stopped, leaving his wife and family to have to resort to Poor Law relief.'[27] For Anderson, asylum detention was a step to distress. In March 1917, Gerard Hohler (1862-1934), a Conservative politician who worked actively for dockyard workers in Chatham and Gillingham, made a provocative statement about the poorer class of shell-shocked soldiers that:

> It has always produced in my mind a great sense of injustice. I refer to the soldier or sailor who, in fact, has become insane at the war. It may be a temporary insanity. We hope it is, but we know that in many cases it will be a permanent one. What is the result? That man is sent either to the infirmary or the asylum; probably to the asylum-almost certainly after a few days at the infirmary-and it is common knowledge in this House that the minimum charge for a county asylum is 14s a week. What happens? That man is sent to the asylum, and the guardians thereupon claim, under the Acts of Parliament existing, the right to deduct from that pension this 14s. It leaves the woman and children little or nothing. They have to depend entirely upon what the guardians may be willing to give them. ... They have no right to complain. This man, with others, has contributed to making everything of value in this country. Without our soldiers and sailors, where are we? We are hopeless...[28]

Through shell shock, working-class soldiers were forced to follow a path to distress. This led political guardians to take action in Parliament.

Individual Petitions to Avoid the Stigma of Lunacy

Behind the political movement for the special relief of the shell shock were specific individual petitions. In August 1918, Frederick William Jowett (1864-1944), the

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[27] *Parliamentary Debates, House of Commons* , Vol. 87, 1916, p. 783.
[28] *Ibid*, Vol. 91, 1917, p. 317.

chairman of the Independent Labour Party and MP from West Bradford, brought into the Commons the case of James Burton who was a NCO sent to Egypt and Salonika. In Salonika, he had had a nervous disorder and was sent into a hospital in Malta. After being discharged from the Army, he was detained at a lunatic asylum at Menston in Yorkshire.[29] In this asylum, Burton became a pauper lunatic. This was humiliating to his relatives, because, in pauperising him, the poor law authority decided that he was unable to pay 12 shillings a week, without asking his family. Dissatisfied with this disposal, his family petitioned Jowett, who then asked whether the War Office would take any special action against this.

At the same time, Ellis Hume-Williams (1863-1947), the chairman of the Central Prisoners of War Committee and Conservative MP from Nottinghamshire, reported a case of a gentleman's son living near Manchester. He was a private in the war and was invalided owing to 'nerve strain.'[30] Because of this disease, he was admitted firstly into the Maghull Military Hospital - a military mental hospital converted from a lunatic asylum, but was suddenly sent to a public asylum at Prestwich without any notice to his father. In this case, too, the problem was that the father, deprived of looking after his son, felt humiliated. Both cases show how English people felt the humiliation of lunacy and asylum incarceration.

Not only in England, but also in Scotland, politicians were petitioned for political relief for the shell-shocked. One case was brought by William Kidston, an iron merchant in Glasgow and a member of the foster family of Andrew Bonar Law, the leader of the Conservative Party at the time. In February 1915, Kidston sent a letter to Bonar Law (1858-1923) to propose the establishment of a special hospital for soldiers suffering from 'nerve strain' that would enable them to avoid asylum

[29] *Ibid*, Vol. 85, 1916, p. 15.
[30] *Ibid*, p. 1257.

stigma.[31] Bonar Law forwarded the letter to Thomas McKinnon Wood (1855-1927), the Scottish Secretary in the cabinet, who had connections with the Scottish mental health authorities. McKinnon Wood took swift action, replying to Bonar Law that the Commissioners of the Scottish Board of Control were 'all willing to volunteer setting the special hospital.'[32] As a result, a special receiving house that could admit patients of shell shock without legal certification was established in Glasgow.[33] This measure satisfied Bonar Law and Kidston.[34]

Local Resistance to Pauperisation of Soldiers

From 1917, local authorities joined the political opposition to the asylum treatment of shell shock, specifically to the pauperisation of nervous soldiers. In Lancashire, the local asylum board initiated resistance against incarceration of shell-shocked soldiers in lunatic asylums, paying particular attention to the situation that they were pauperised in the confinement process. In February, William P. Byles (1839-1917), the descendant of the founder of the *Yorkshire Observer* and Liberal MP from Salford, referred to the local protest of the Lancashire Asylums Board against the War Office's measure that:

> Soldiers and sailors who have served their country abroad and have returned home mentally deranged being discharged from the Navy or Army and sent to the asylums, and their maintenance being charged to boards of guardians as if they were pauper lunatics, and against the families of such patients having in some cases not been left with sufficient to live upon.[35]

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[31] BL/36/4/42 (Bonar Law Papers, Parliamentary Archives).
[32] *Ibid.*
[33] *Lancet*, September 11, 1915, p. 623; *British Medical Journal*, January 8, 1916, p. 42.
[34] BL/36/4/49 (Bonar Law Papers, Parliamentary Archives).
[35] *Ibid*, Vol. 90, 1917, p. 1689.

In July, newspapers in northern England, such as the *Manchester Guardian*, *Evening Standard*, *Liverpool Post*, *Preston Herald*, and *Liverpool Courier*, reported political protest in Lancashire. According to them, the Lancashire Asylum Board considered the pauperisation of shell-shocked soldiers as unjustifiable, thereby proposing to 'fight the powers' of the pension authority.[36] This action received wide support in Lancashire politics. For instance, Travis Clegg (1874-1942), the Alderman of Lancashire County Council, Sir Harcourt E. Clare (1854-1922), the clerk to the Financial Committee of the Board and Sir Norval Helme (1849-1932), Members of Parliament, were all supportive of the local resistance to the pauperisation of shell-shocked soldiers.[37] The Blackburn War Pensions Committee also decided to support the proposal made by the Lancashire Asylums Board, and expected the Ministry of Pensions to accept its criticism.[38] Peter Barham, a historian of English psychology, has noted similar incidents in Birmingham and Cornwall.[39] In both regions, the asylum authorities were of the opinion that shell-shocked soldiers should not be involved with lunatic asylums and the Poor Law. Instead, they proposed that the pension authorities provide non-lunacy and non-pauperising large houses for them.

During the Great War, many Britons concentrated their attention on provision of special relief for shell-shocked soldiers. These soldiers were not forgotten politically, as Peter Barham has argued. Nor were they provided with disciplinary treatment, as Elaine Showalter has argued. Rather, in the changing notion of mental diseases in the war, the war heroes whose minds were wounded

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[36] *Liverpool Post*, 26 July, 1917. Also see MH51/693 (National Archives).
[37] *Preston Herald*, 28 July, 1917; MH51/693.
[38] *Blackburn Times*, 1 September, 1917; MH51/693.
[39] Peter Barham, *op.cit.*, pp. 181-182; MH51/693.

were patronised considerably by politicians and the local authorities. Mathew Thomson has argued that such political sympathy was framed by 'contemporary thinking about citizenship.'[40] This is partly true, but may not be precise enough. The political relief for the shell shock did not arise from a specific political ideology but from the individual and paternalistic politicians who maintained their supporters' health and social respectability.

3. The Governmental Relief for Shell Shock

Facing political and local resistance, the War Office initiated a special provision of non-asylum and non-certifying treatment for the shell-shocked soldiers. This task was not difficult for the War Office, because it had already established 'military hospitals for nervous soldiers' separate from the lunacy administration.

By January 1915, the War Office decided to establish special military hospitals for soldiers of 'nervous shock.' Number 144 of the Army Council Instruction issued in March 1915 referred to seven military hospitals at Netley in Hampshire, Maghull near Liverpool, Wandsworth in Surrey, Napsbury in Middlesex, Queens Square (London), Maida Vale (London), and Denmark Hill (London).[41] In May 1915, the Director-General of the Army Medical Services instructed that all the territorial general hospitals throughout England, Scotland and Wales should establish neurological sections for nervous and shell-shocked soldiers.[42] In 1916, the Army additionally converted at least five asylums in St. Albans, Warrington,

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[40] Mathew Thomson, *op.cit.*, 2000, pp. 231-232.
[41] W.G. Macpherson, W.P. Herringham, T.R. Elliott, and A. Balfour (eds), *History of the Great War Medical Services, Diseases of the war*, Vol. 2, pp. 45-50; WO293/2: Army Council Instructions of 1915[1] (National Archives). Also see Peter Leese, *op.cit.*, pp. 68-69.
[42] *Lancet*, 27 May, 1916, pp. 1073-1075.

Paisley, Perth, and Belfast into military mental hospitals.[43] It also provided further military neurological hospitals in London and Edinburgh.[44] Finally, 19 shell shock hospitals provided 1,200 beds for officers and 4,500 beds for the rank and file.[45] In these hospitals, patients were not legally certified as regulated by the Lunacy Act of 1890, but were treated under the Army Act.

Some of the shell-shocked soldiers, however, were detained as pauper lunatics at asylums because they were more than 6,700 in total. To solve this issue, in August 1916, the War Office asked the War Pensions Statutory Committee and the Board of Control to consider a special measure in order to avoid pauperising shell-shocked soldiers in lunatic asylums.[46] The Board of Control replied that:

> There is a strong and widely prevalent feeling, which the Board share, that sailors and soldiers, who have lost their mental balance while on active service in the course of the present war, should not be classed as paupers and should be relieved of the stigma which has become associated with that term.[47]

To prevent the pauperisation of shell-shocked soldiers, the Board of Control suggested the 'service patient' scheme. By this provision, shell-shocked soldiers were granted a state pension that covered the non-pauper rate of their maintenance in asylums, and were allowed to wear a distinctive uniform and badge. This special

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[43] WO293/4: Army Council Instructions of 1916[1].
[44] WO293/5: Army Council Instructions of 1916[2].
[45] W.G. Macpherson, W.P. Herringham, T.R. Elliott, and A. Balfour (eds), *op.cit.*, pp. 47-48; WO293/8: Army Council Instructions of 1918[1]. The military hospitals were: for officers, the Maudsley Neurological Cleaning Hospital at Denmark Hill in London, Special Hospital for Officers at Palace Green in London, Red Cross Military Hospital in Maghull near Liverpool, Officers Hospital at Nannau in Dolgelly, Craiglockhart War Hospital in Edinburgh, King's Lancashire Military Convalescent Hospital in Blackpool; for rank and files, the Maudsley Neurological Cleaning Hospital, Springfield War Hospital in Upper Tooting, Red Cross Military Hospital, Abram Peel Hospital in Bradford, Ewell War Hospital in Surrey, 1st Southern General Hospital in Birmingham, Glen Lomond War Hospital in Fife, Dunblane War Hospital in Perthshire, Seale Hayne Neurological Hospital in south Devon, Gateshead War Hospital in Newcastle-upon-Tyne, Neurological sections of the 4th Southern General Hospital in Plymouth and of the 2nd Western General Hospital in Stockport (WO293/8).
[46] MH51/239 (National Archives).
[47] *Ibid.*

scheme was approved by the majority of local authorities, because it guaranteed that they had no responsibility for the expense spent on the shell-shocked.[48]

However, local opposition remained, partly because the new scheme, although classifying shell shock soldiers differently from ordinary pauper patients, would still admit them into lunatic asylums under the Lunacy Acts. For this reason, some local authorities insisted that shell-shocked soldiers should be treated in 'establishments - formed out of houses rented in various parts of the county - in no way connected with asylums or mental hospitals.'[49]

To defend the original scheme, in March 1917, the Board of Control stated that the project was so urgently needed that local authorities did not have enough time to establish new institutions.[50] It also emphasized that service patients were equal to 'private patients' in status, although it did not refer to the kind of legal certification that should be applied to them.

In July, the service patient scheme was confirmed in the inter-ministerial meeting between the Board, the War Office and the Statutory Committee. Among them, the Board was practically in charge of the scheme.[51] Its primary provision was to classify and treat shell-shocked soldiers as private patients in the name of 'service patients' in lunatic asylums.[52] They were paid pensions by the Statutory Committee to cover the payment charged by asylums and the maintenance of their wives and children. Additionally, they were allowed to wear a distinctive semi-military uniform and a special badge in asylums.[53] Under the scheme, 198 service patients were treated in asylums in the initial stage, but they continued to increase

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[48] MH51/694.
[49] MH51/239.
[50] *Ibid.*
[51] MH51/694. Also see *Annual Report of the Board of Control*, 1918, pp. 23-31.
[52] *Ibid.*, p. 25.
[53] *Ibid.*, pp. 25-26; MH51/239.

significantly.[54] In 1922, 4,985 service patients were in 91 public asylums in England and Wales.[55]

In response to the wartime politics in favour of non-certifying, non-asylum and non-pauperising psychiatric services, the government endorsed the hospitalised treatment and the service patient scheme.

4. Shell Shock and Politics of English Psychiatry

Shell Shock and Lunacy Legislation

The change in the political climate had an impact upon the rhetorical strategy of English psychiatry, since it chimed with the pre-war claim of the psychiatric profession for the 'early treatment of mental disorder.' In January 1916, Bedford Pierce (1861-1932), medical superintendent of the York Retreat, revived the political insistence for early treatment at the meeting of the Yorkshire Branch of the BMA, in a paper entitled 'Absence of proper facilities for the treatment of mental disorders in their early stages.' In this, Pierce argued the necessity of early treatment as pre-war psychiatric doctors had done, but he gave a new emphasis. To reinforce the idea of early treatment, he referred to the wartime non-medical demands for non-certifying psychiatric treatment:

> General public attention was called to the matter [the absence of proper facilities for treatment of nervous and mental disorders in their earlier stages], when it was realised that, apart from certification, there was no legal method

[54] MH51/694.
[55] Peter Barham, *op.cit.*, pp. 371-373. Also see MH51/239.

> of treating soldiers temporarily disordered in mind. It was at once seen that the existing procedure was impossible for men temporarily broken down in the service of their country.[56]

Following Pierce, Richard Gundry Rows (1860-1925), medical superintendent of the Maghull military mental hospital near Liverpool, provided a successful tale of early treatment in wartime for the justification of psychiatric politics. In peacetime, he was the pathologist to the Lancaster County Asylum and secretary to the Committee on Status of British Psychiatry of the MPA. In the latter role, he contributed to the Committee's Report that strongly recommended early treatment of mental disorder. In wartime, Rows found an opportunity to practice this recommendation, because military mental hospitals could legally admit nervous and mental soldiers without certifying them as insane. According to him, the result was successful. In March 1916, he reported in the *British Medical Journal* that many of the incipient mental cases were curable and co-operative with doctors in Maghull, and that they were discharged or returned easily to the front.[57] Referring to this experience at military hospitals, he justified the MPA's proposal for early treatment. The success story of Maghull was, as Ben Shephard has argued, pioneering in the later development of outpatient psychotherapeutic clinics in the interwar period. But this is not entirely correct.[58] Importantly, Row's story was connected firmly with psychiatrists' legislative campaign for early treatment started from 1896.

Pierce and Rows' moves were followed by medical and psychiatric journals. In September 1917, a *Lancet* editorial observed a change in parliamentary opinions

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[56] *Lancet*, January 8, 1916, p. 41.
[57] *British Medical Journal*, March 25, 1916, p. 441.
[58] Ben Shephard, *op.cit.*, p. 161. Also see Ben Shephard, 'The early treatment of mental disorders: R.G. Rows and Maghull 1914-1918,' in Hugh Freeman and German E. Berrios (eds), *op.cit.*, 1996, pp. 434-464.

about lunacy administration, and argued that this change should not 'hold good only for the duration of the war.'[59] In another leading article published in October, *The Lancet* argued that the 1890 Act obstructed the treatment of shell shock, since it did not allow treatment of incipient mental disease in non-asylum accommodations without certification.[60]

Famous non-psychiatric psychologists also opposed military treatment of shell-shocked soldiers and supported the political move for early treatment: Grafton Elliot Smith (1871-1937), Professor of Anatomy at Manchester University, and Tom Hatherley Pear (1886-1972), lecturer of experimental psychology there. Neither were psychiatrists, but had engaged in the treatment of shell shock in the military hospital at Maghull. Their experiences there led them to co-author *Shell Shock and its Lessons* which reinforced the medical advocacy for early treatment. The primary purpose of this book was to describe the success of the early treatment of mental diseases, but Smith and Pears also concentrated on criticism of the non-therapeutic nature of the 1890 Act because they believed that 'if the lessons of the war are to be truly beneficial, much more extensive application must be made of these methods, not only for our soldiers now, but also for our civilian population for all time.'[61] The major defect of the Act, they argued, was that lunacy certificates and its stigma deterred prospective patients from accessing psychiatrists' treatment. They criticised not only the Act, however, but also the public discriminating against the mentally ill:

> If... we consider the attitude of the general public in this country towards the malady of insanity we find a mixture of ignorant superstition and

[59] *Lancet*, September 1, 1917, p. 353.
[60] *Ibid.*, October 20, 1917, pp. 612-613.
[61] G. Elliott Smith and T.H. Pear, *Shell shock and its lessons*, Manchester: Manchester University Press, 1917, p. 81.

> exaggerated fear. From these there springs a tendency to ignore the painful subject until a case occurring too near home makes this ostrich-like policy untenable. The sufferer is removed to a 'lunatic' asylum, neither himself nor his relatives being spared the gratuitous extra wrench to their feelings aroused by this name, which has long struck terror into the uneducated mind. ... The attitude of the general public is not deliberately cruel, but it appears to be far more benevolent than it really is. The community treats the sufferer well, when, but not before, he has become a 'lunatic.' It allows his delusions to become fixed, his eccentricities and undesirable acts to harden into habits, his moods of depression to permeate and cement together the whole of his life - and then interns him and treats him kindly for the rest of his life, but does not give him facilities for gratuitous treatment while he is still sane. [62]

On these grounds, they proposed the establishment of outpatient clinics at general hospitals for incipient cases of mental disease. With this facility, Smith and Pear believed, patients would not hesitate to visit because the psychiatric clinic would not be regarded by the public as a 'lunatic' asylum.[63]

Smith and Pear provoked English psychiatrists into the political move for early treatment. Referring to wartime psychiatry, in 1918, an editorial of the *Journal of Mental Science* also legitimised the early treatment of mental disorder:

> A large number of patients cannot be treated to recovery in them [military hospitals], and will have to be transferred to a hospital for the insane. And surely, it is cruel and reactionary in the extreme to reproach the more grave cases with the stigma of madness and to imply that they are something different from those who happen to recover quickly. The Medico-Psychological Association has striven, since its foundation, to remove the reproach of lunacy, and we cannot but regret to see it being emphasized in order to help forward a needful reform in treatment. The assertion that 50 per cent., or nearly 50 per cent., will escape the fate of "being branded as madmen," when considered in relation to the context, evidently means that declared insanity will be prevented in half the cases. This is surely too sanguine a view, and there are certainly no statistics available to justify so sweeping a statement. We must not forget that it is the disease itself which is serious, not what it is called, nor where it happens to be treated.'[64]

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[62] *Ibid,* p. 79.
[63] *Ibid,* p. 81.
[64] *Journal of Mental Science,* 1918, p. 213.

This narrative was almost the same as that put forward by pre-war psychiatrists, but it was given new emphasis through the experience of wartime psychiatry. The *Journal of Mental Science* sought the treatment of the shell-shocked in non-asylum hospitals without legal certification to be applied to the peacetime legislation:

> The war has forced upon this country a rational and humane method of caring for and treating mental disorders among its soldiers. Are these signs of progress merely temporary? Are such successful measures to be limited for the duration of the war and to be restricted to the Army?'[65]

They hoped not.

With the support of non-psychiatrists, the Parliamentary Committee of the MPA in 1918 resumed its legislative campaign for the amendment of the 1890 Act, expressing its objection to certification of early and curable cases.[66] In January, in a letter to the *British Medical Journal*, the Committee declared that the MPA reconsidered the defects in the existing legislation that were found in the treatment of shell shock. Several months later, it completed a draft for new legislation that highlighted general hospital psychiatry for mild mental cases without legal certification, and with emphasis on 'the experience gathered as the result of the war.'[67]

Other psychiatrists welcomed the revival of the political claim for early treatment of mental diseases. G. M. Robertson (1864-1932), medical superintendent of the Edinburgh Mental Hospital at Morningside, pointed out that 'public opinion was growing more averse to sending persons suffering from short and recoverable attacks of insanity to asylums, as thereby not only does a certain stigma, unjust though it be, attach to them,' and argued that 'there is no essential difference

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[65] *Ibid.*, p. 211.
[66] The Report of Lunacy Legislation Sub-Committee, pp.6-7 in LCO2/477 (National Archives, Kew).
[67] MS4578 (Wellcome Library Western Manuscripts and Archives).

between the case of the soldier who becomes insane in the defence of his country and that of a woman who suffers from an attack of puerperal mania, and that it is injustice not to accord to the civilian privileges similar to those which have been provided for the officer.'[68] In 1919, Robert Armstrong-Jones, the consulting physician in psychological medicine to St Bartholomew's Hospital, claimed that 'the war had taught us that it was possible to deal with incipient mental symptoms in the ordinary military hospitals,' and he hoped to see it possible for every case of mental illness to be treated in the earlier stages in general hospitals.[69] In 1923, similarly, Frederick Walker Mott justified the claim for early treatment, by referring to the wartime public opinion as to treatment of shell-shocked soldiers.

> The rooted objection to the treatment of early cases of insanity in asylums, and the stigma being certified a lunatic and sent to an asylum without a period of probation had been growing in the public mind since before the war; and when it was found that great numbers of soldiers were being discharged for shell-shock and war neuroses and psychoses, public feeling ran high against these men (who were believed to have become insane owing to the terrors, stress, and strain of war) being sent to lunatic asylums without a period of probation. Questions were asked in Parliament, and it was enacted that no soldier should be discharged and sent to an asylum, unless it could be shown that he was suffering from an incurable mental disease.[70]

Not only psychiatric doctors, but medical critics responded to the psychiatrists' campaign. In January 1918, an editorial of *The British Medical Journal* agreed to the statement of the MPA that 'the need for amendment has been accentuated by the many cases of shell shock and other forms of mental derangement in its earlier stages arising out of the war, but reform has long been

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[68] *British Medical Journal*, March 9, 1918, p. 300.
[69] *Transactions of the Medico-Legal Society*, 1919-1920, p. 2.
[70] James Marchant, *The claims of the coming generations: a consideration by various authors*, London: K. Paul, 1923, p. 43.

required in the interests of the civil population.'[71] In response to this, the BMA, devoting the top pages of its journal, argued that the current lunacy legislation deterred early treatment of mental diseases with legal certification, but 'in the army none of these difficulties stand in the way; large numbers of cases of recent mental disturbance have been dealt with in special hospitals for "functional nervous disorders" without certification in the vast majority of cases.'[72] For example, in a military hospital at Warrington, lunacy certification was applied only to only 192 of 3,800 cases; the rest of them could avoid 'the stigma of insanity and pauperism.'[73] This kind of treatment, the BMA insisted, should be incorporated in the peacetime legislation on lunacy. Keeping up with the MPA and the BMA, *The Lancet* also advocated the application of wartime psychiatry. In January 1918, it stated 'the simple and rational measures devised for the handling of mental cases among service patients must inevitably punctuate the necessity of revision of present-day lunacy laws.'[74]

Wartime Reconstruction

The idea of applying wartime psychiatry to peacetime legislation appeared as a part of the governmental plan for war reconstruction. In August 1916, the Reconstruction Committee asked the Board of Control about the issues that the Board wanted to raise in the governmental plan of reconstruction.[75] Its intention

[71] *British Medical Journal*, January 26, 1918, p. 124.
[72] *Ibid.*, March 9, 1918, p. 291.
[73] *Ibid.*
[74] *Lancet*, February 2, 1918, p. 185.
[75] MH51/687. Also see Kenneth and Jane Morgan, *Portrait of a progressive: the political career of Christopher, Viscount Addison*, Oxford: Oxford University Press, 1980, pp. 70-82.

was to establish a new administrative system for the 'health of the population,'[76] including 'the provisions of general and specialist medical services of every kind, precautions against possible epidemic diseases after the war, and the treatment of particular diseases that are commonly spread by war.'[77] This offer was perceived by the Board of Control as a chance for challenging the 1890 Act.

From the 1910s, the Board increasingly became an authority of national health, no longer a watchdog of malpractices of asylums, because the Mental Deficiency Act of 1913 reinforced the medical character of the central administration of mental health. In particular, the 1913 Act reorganised the Commissioners in Lunacy into the Board of Control that newly had five Commissioners from medicine: namely, C. Hubert Bond (1870-1945), E. Marriott Cooke (1852-1931), Frederick Needham (1836-1924), and Sidney Coupland (1849-1930). The medical Commissioners played a role as health administrators and endeavoured to promote the position of psychiatry in medicine and science rather than in law. Bond and Cooke especially spoke for the MPA and promoted early treatment.

The Board of Control thus took up the offer of the Reconstruction Committee and proposed an amendment to the Lunacy Act of 1890 for improvement of 'the health of the population.' The Board explained to the Committee that a number of difficulties in English psychiatry endured after 1890. In particular, similarly to the 1914 Report of the MPA, it problematised the absence of early treatment and its consequence of less remedial provisions for mentally ill populations. On these grounds, it proposed that outpatient clinics be established in general hospitals for the treatment and study of mental and nervous diseases in

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[76] MH51/687.
[77] *Ibid.*

incipient and earlier phases. In this provision, reasonably, the legal certification was avoided.

Like psychiatrists and other medical critics, the Board of Control justified the early treatment idea by referring to the wartime psychiatry supported in Parliament. In the correspondence with the Reconstruction Committee, it remarked that it had introduced the service patient scheme 'to meet the pronounced opposition both in and out of Parliament to the certification of soldiers who during the war suffer from mental breakdown.'[78] In this special provision, mentally wounded soldiers were cared for and treated without legal certification. After referring to the advantage of the wartime psychiatry, it concluded that:

> The public prejudice against the so-called "stigma" of certification has in no small degree been the cause of and created the necessity for this special arrangement. It is a prejudice which has always existed and has to be recognised and reckoned with in civilian life. In the opinion of the Board it has ever been a hindrance to the early treatment of mental disease with the result that, in all asylums, there are numbers of patients suffering from incurable insanity.[79]

This was a reiteration of the idea of early treatment of mental disorder. The Board of Control thus became representative of the psychiatric profession.

In April 1917, the Board of Control was consulted by an influential member of the Reconstruction Committee on another ongoing reconstruction plan related to the lunacy administration.[80] The member was Beatrice Webb (1853-1943), and her concern was about the influence of her idea of abolishing the Poor Law authorities' power over lunacy administration. This separation of the lunacy administration from the Poor Law was a long-waited plan of English psychiatrists, so that the

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[78] *Ibid.*
[79] *Ibid.*
[80] MH51/688.

Board replied to her with its approval. In doing so, it emphasized that the separation would be beneficial in promoting early treatment of insanity.[81] The early treatment of mental disorder, in this way, became an important topic through the war.

5. Shell Shock and the Mental Health Market

Rise of Neurology

Not only did the war assist with the psychiatric politics for the early treatment, but it also caused a new market situation. This new circumstance was primarily caused by the War Office's appointment of a number of non-psychiatric doctors, mainly including neurologists, as consultants in charge of shell shock. In late 1914, the War Office appointed William Aldren Turner (1864-1945), physician specialising in neurology to the King's College Hospital and National Hospital for the Paralysed and Epileptic, as special medical officer in charge of wartime nervous disease. By early 1916, it also appointed Gordon Morgan Holmes (1876-1965), physician to the National Hospital for Nervous Diseases, and Charles Samuel Myers (1873-1946), a Cambridge experimental psychologist, as consultant doctors at the front. At home, the War Office converted such eminent neurological institutions as the National Hospital for the Paralysed and Epileptic, the Maida Vale Hospital for Epilepsy and Paralysis, and the West End Hospital for Diseases of the Nervous System, into military hospitals to deal with nervous soldiers. In addition to these, it also introduced neurological sections to all the general territorial hospitals in which it

[81] *Ibid.*

appointed many unknown physicians and practitioners who had rarely seen mental and nervous cases in practice. In and after the war, many of them began a practice in mental and nervous cases.[82] It should be noted, however, that the neurological practice had continuously developed since the late nineteenth century.[83] Importantly, it did not spread to the extent to which psychiatrists thought neurology as a menace to themselves. Thus, the wartime rise of neurological practices was unexpected and unwanted by psychiatric doctors.

The rise of neurology followed the construction of knowledge about the 'unknown' breakdown of soldiers in France. In late October 1914, this war-related breakdown was not a disease of nerves. Initially, *The Lancet* reported it as 'an uncanny effect of shell artillery.'[84] By late 1914, however, this mysterious breakdown was recognised as a disease of nerves connected with the stress and strain of modern warfare.[85]

Facing the emergence of a new kind of nervous disease, the medical press called for specialist interventions. The *British Medical Journal* stated that the nervous cases were not suitable for general hospitals, but should have rest treatment under medical specialists.[86] The specialists were not psychiatrists but physicians specialising in neurology, physiology and experimental psychology. From early 1915, medical writers increasingly identified soldier's breakdowns as 'nervous disease.' The *British Medical Journal* argued that it was an organic and functional nervous disease accompanying lesions in brain and cord,[87] and *Lancet* editorials remarked that soldiers' breakdowns were nervous injuries caused by 'shell

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[82] Peter Leese, though referring to non-psychiatrists' treatment of shell shock in wartime, argued little about its political and economic impact (Peter Leese, *op.cit.*, pp. 90-99).
[83] Janet Oppenheim, *op.cit.*, pp. 31-34.
[84] *Lancet*, October 31, 1914, p. 1058.
[85] *Ibid.*, December 12, 1914, p. 1388.
[86] *British Medical Journal*, November 7, 1914, pp. 802-803.
[87] *Ibid*, July 10, 1915, p. 64.

explosions and its explosive winds.'[88] In 1916, Frederick Walker Mott, the pathologist to the London County Council Asylum at Claybury and physician to Charing Cross Hospital, argued that the cause was injuries of the cerebral-spinal cord, or the central nervous system, caused by high explosives.[89]

The construction of wartime nervous diseases was also conducted by experimental psychologists and doctors familiar with psychoanalysis. Charles Samuel Myers, a Cambridge experimental psychologist, in February 1915, termed the mysterious breakdown of soldiers as 'shell shock,' because shell explosions caused a strong impulse that deprive soldiers of their senses of memory, vision, smell and taste, all of which were organs related to 'nerves.'[90] Sympathizers with Freud also regarded soldiers' breakdown as related to nerves. To express the breakdown, David Forsyth (1877-1941), a physician to outpatients at the Charing Cross Hospital, employed the term of 'functional nervous disease.'[91] This disease was not necessarily to be based on specific physical lesions, but indicated a collective category of diseases that could not be explained by surgical and physiological knowledge.

In the early stages of the war, however, this mysterious breakdown was not conceived exclusively in terms of nervous diseases. The medical press and military authorities often wrote down both adjectives of 'mental' and 'nervous' to this phenomenon.[92] In their understanding, nervous disease was a milder form of, or a morbid condition on the eve of, mental disease. Only later in the war was it generally referred to nervous disease. For instance, the Army Medical Services

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[88] *Lancet*, August 14, 1915, p. 348; *Ibid.*, October 2, 1915, p. 766.
[89] *Ibid.*, February 12, 1916, pp. 331-338; *Ibid.*, 26 February, 1916, pp. 441-449; *Ibid.*, 11 March, 1916, pp. 545-553.
[90] *Lancet*, February 13, 1915, pp. 316-320.
[91] *Ibid.*, December 25, 1915, pp. 1399-1403; *Ibid.*, December 25, 1915, pp. 1399-1403.
[92] WO293/2: Army Council Instruction of 1915 [1].

increasingly employed the term of nervous disease,[93] and Parliamentary members gradually expressed the breakdown as 'nerve-shattered' conditions and 'nerve shock,' rather than insanity or lunacy.

What enabled the rise of wartime neurology, apart from the actual demand for governmental services produced by the war? Importantly, the War Office was forced to consider a special provision that would 'not hamper soldiers' future by the infliction of stigma of asylum and pauper.'[94] Such political pressure was caused not only by politicians but also by medical critics. In early 1915, *The Lancet* stated that the medical department of the War Office should act 'with due consideration for individuals, and for the welfare of the community, as well as for the prosecution of the war to a successful issue.'[95]

In this context, the wartime rise of neurology was important; the term 'nervous' enabled soldiers broken down without apparent wounds not to enter lunatic asylums, thus avoiding the stigma of legal certification. In this sense, nervous disease did not have to be literally a disease of nerves. Rather, it was a labelling as not 'insane.' A leading editorial in *The Lancet* published in May 1915 observed a public feeling of anxiety:

> Lest the soldier patients sent there for treatment are being relegated to the category of the insane and may suffer in after life from the prejudice which the vulgar unfortunately entertain against the victim of mental disease' and made a proposal that non-asylum treatment be made for 'treating soldiers suffering from nervous shock in specially organised departments in connection with general hospitals.[96]

[93] WO293/5-8: Army Council Instruction of 1916[2]-1918[1].
[94] *Ibid.*, January 23, 1915, pp. 189-190.
[95] *Ibid.*
[96] *Ibid.*, May 1 1915, pp. 919-920.

To return such soldiers into society without unnecessary anxieties about certification as lunatics, they should be 'nervous' cases. Similarly, *The British Medical Journal* stated in 1917 that 'even a short residence in a mental hospital, which is more commonly called a lunatic asylum, impresses on him a stigma not felt in the cases of persons who have been inmates of hostels for neurasthenic patients.'[97]

The Market Competition of Psychiatry in the War

The rise of cases of nervous diseases in the war generated a new market contest between psychiatrists, neurologists and psychoanalysts. Additionally, a large number of doctors, who had not described themselves as expert neurologists and psychiatrists, began seeing mental and nervous cases during and after the war.

The increasing role of neurology in wartime led to the question: which medical specialty should be in charge of treatment of nervous diseases - milder and incipient cases of mental disease, psychiatry or neurology. Prior to the war, the MPA and psychiatric consultants wished to establish psychiatric departments in general hospitals without legal certification for the treatment of such milder cases. In this scheme, specialists in charge were psychiatrists. Hence, it was problematic that neurologists developed hospital treatment for milder mental diseases. The wartime rise of neurology was deemed as producing a market competition between two medical specialties.

Between July and September in 1915, there was a controversy entitled 'Hospital Treatment v. Lunacy Treatment' in *The Lancet*. This was opened not by

[97] *British Medical Journal*, March 3, 1917, p. 302.

psychiatrists and neurologists but by a radical female physician Sara Elizabeth White, late demonstrator at the London School of Medicine for Women and a general practitioner specialising in mental disease in Ireland. In July 1915, she called for hospital treatment for nervous soldiers, dismissing asylum doctors from it. She remarked that 'we need for the treatment of mental trouble something very different from the crude domination so often administered by ignorant, well-meaning, but quite incompetent nurses and care-takers.'[98] By 'the crude domination,' she meant asylum treatment.

Psychiatric doctors immediately objected to the dismissal from treatment of mild cases of mental disease. To defend psychiatric jurisdiction, George Henry Savage wrote to *The Lancet* that psychiatric doctors 'wished to have an insane ward attached to a general hospital, but only those who have practical experience of mental disorders know the danger and difficulties in treating many cases, even in their earlier stages.'[99] He added:

> Surely in recent years the neurologist has been responsible for the early treatment of mental disorders, yet I have to learn that in consequence any advance has been made. Routine rest cures and travelling have been more in fashion, but I do not think the results have been made any better than that advised by psychiatrists.[100]

Despite the fact that White was not a neurologist, Savage attacked neurologists' encroachment upon psychiatrists' jurisdiction. In reply, White challenged Savage, contending that general practitioners could easily become specialists if training were

[98] *Lancet*, July 24, 1915, pp. 199-200.
[99] *Ibid.*, July 31, 1915, p. 250.
[100] *Ibid.*

provided, and emphasised the disadvantage of psychiatrist's treatment and its social stigma.[101] She attacked psychiatrists but did not represent neurologists.

Significantly, no famous neurologist joined this dispute. However, psychiatrists showed their worries about the rise of neurology. Their anxieties seemed to focus on the expansion of neurological practices. Certainly, unknown physicians began seeing war-related nervous diseases, although most of them did not usually proclaim themselves neurologists. It is observable in the membership of the MPA at the time; it shows that doctors who had no relation to asylums in their careers began operating private practices connected with the military neurological and mental cases, through the consulting positions of the Ministry of Pensions. During and after the war, neurological hospitals in London, too, recorded remarkable extensions in their outpatient and inpatient departments. Table 5-1 shows the admission statistics of the Maida Vale Hospital for Nervous Diseases and West End Hospital for Nervous Diseases. The growth seen in this table was directly drawn on the outbreak of shell shock, and indirectly, because these neurological hospitals could increase beds apart from the restriction of the 1890 Act. Under the Act, the public and private sectors of psychiatry did not have accommodation enough for the rapid increase in demands. However, both the Maida Vale and West End Hospitals could provide extensive provisions, because their businesses were not restricted by the state.[102] Because of this, these hospitals could play an important part in meeting the increasing demands for neurological treatment in the wartime and post-war period.

[101] *Ibid.*, August 14, 1915, pp. 359-360.
[102] SC/PPS/093/35; 76 (London Metropolitan Archives).

Table 5-1. In/Out Patients and Finances at the Maida Vale Hospital for Nervous Diseases and West End Hospital for Nervous Diseases, 1900-1930

	Maida Vale Hospital						West End Hospital					
	No. Inpatient	No. Outpatient	Total	Income			Inpatient Admission	Attendance to Outpatients	Total	Income		
				Total	Patients' Payment	Funds				Total	Patients' Payment	Funds
1900	46	431	477	£1,068	£345	£608	360	22886	23246	£4,489	£522	£2,658
1910	268	1392	1660	£3,748	£852	£2,877	237	25618	25855	£5,137	£343	£4,759
1914	468	2828	3296	£5,147	£1,315	£3,750	254	31016	31270	£6,896	£990	£5,837
1920	580	4114	4694	£10,652	£4,851	£5,156	445	42122	42567	£13,999	£6,707	£6,050
1925	1027	4958	5985	N/A	N/A	N/A	526	46508	47034	£16,598	£6,038	£9,367
1930	663	5933	6596	£12,632	£5,724	£5,980	498	40681	41179	£15,679	£6,500	£7,336

Sources: SC/PPS/093/35; 76 (London Metropolitan Archives).

Psychiatrists sought a compromise with neurologists, urged by non-psychiatrists. In September 1915, a parliamentary member, W. A. Chapple (1864-1936), a Liberal MP for Stirlingshire and previously a physician to the Wellington Hospital, joined the controversy. He criticised treatment by psychiatrists because of its stigma, but defended their interests in milder cases of mental diseases outside asylums. He remarked that 'our best psychiatrists would come into the hospital domain, enjoy the status, and do the very excellent kind of work that is now done by the specialists in our other great hospital departments.'[103] In so saying, he possibly suggested cooperation between medical professions. After this, psychiatrists often proposed cooperation between the two professions. In 1923, Frederick Walker Mott proposed a more specific way of cooperation between psychiatry and neurology:

> They [mental hospitals] should have out-patient clinics, and be called 'neurological and psychiatric clinics, as experience shows that much less objection would arise in getting borderland and early cases of mental disorder to attend if the word "mental" were kept out of the title. An argument in favour of the association of "neurological and psychiatrical" is that there is no hard and fast line between functional neuroses and the psychoses. They belong to one group of mental ill-health and instability...[104]

[103] *Lancet*, September 4, 1915, pp. 569-570.
[104] James Marchant, *op.cit*, p. 46.

In the interwar period, Lionel Weathery, the late proprietor of a Bailbrook private asylum in Bath, insisted on the necessity of 'hand-in-hand' work between psychiatrists and neurologists. The medical press also proposed the cooperative involvement of psychiatry, neurology and general medicine. A *Lancet* editorial pointed out that from the war:

> Everywhere the practitioners of medicine met with the "shell-shocked" soldiers, and though he may be conscious of his own inability to treat such a case out of a full experience, at least it is borne in on him that the patient cannot be left to his own devices.'[105]

However, it did not insist that the cases should be treated only by specialised branches of medicine, such as neurology and psychiatry. Rather, it proposed that the medical profession as a whole handle such cases. Hence, after the war, psychiatrists were required to make a further endeavour to maintain and extend their market to enclose the increasing demands for treatment of milder cases of mental diseases.

Not only did neurologists encroach upon psychiatry's economic jurisdiction, but physicians infected with Freudian psychoanalysis joined the contest. But in this case, psychiatrists did not seek compromise with them. In late 1915, Charles Mercier intensively criticised the psychoanalytic argument over wartime nervous diseases initiated by David Forsyth. Mercier mainly objected to Forsythe's two sexual causations underlying nervous diseases that these diseases were a specific result of excessive onanism, and that one patient who had broken down under shell-fire proved on analysis to be a case of unconscious homosexuality with marked anal eroticism. These causations were, for Mercier, 'a cruel calumny upon a class of very

[105] *Lancet*, September 1, 1917, pp. 352-353; *British Medical Journal*, September 28, 1918, p. 357.

unfortunate persons,' and labelled the Forsyth's school as 'insidious.' Moreover, Robert Armstrong-Jones remarked in 1916 that Forsyth's hypothesis was 'not only unjustifiable but unproven, and questioned whether one single case had ever recovered through psychoanalysis.'[106] Armstrong-Jones's answer was negative.

Historians of shell shock have argued that during and after the Great War, not a small number of physicians became committed to psychoanalysis, and some of the public press thought highly of the movement.[107] However, by refuting the claim of psychoanalysis, a new psychology, the MPA, the orthodox psychiatry, excluded the school from its post-war strategy.[108] Between the two disciplines was intensive hostility. Nor did psychiatrists stand by psychoanalysis, except William Henry Butter Stoddart (1868-1950) who had had a typical psychiatrist's career as well as being a sympathetic supporter of British psychoanalysis. But he was not recognised fully as a psychoanalyst.[109] As a result of these eminent psychiatrists' criticism, psychoanalysts remained a minor, independent and non-institutionalised group on the edge of the mental health market. Yet, it was a threat to, and an economic encroachment on, the orthodox school of psychiatry.

Facing the economic crisis, the profession of psychiatry accelerated its competition for the market of milder cases of mental disease after the Great War. Such contests in the 1920s are demonstrated in the next chapter.

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[106] *Lancet*, January 22, 1916, pp. 210-211.
[107] Martin Stone, *op.cit.*
[108] Michael Clark argued that psychoanalysis was rejected by psychiatrists because they followed their moral-pastoral responsibility as physicians (Michael J. Clark, *op.cit.*, pp. 271-312).
[109] *International Journal of Psychoanalysis*, 1950, pp. 286-288.

Conclusion

Shell shock provoked intensive parliamentary and local interests in non-asylum, non-certifying and non-pauperising psychiatric services for wartime mental diseases. Following such demands, the Army established military mental hospitals in which shell shocked patients were treated without the stigma of asylums and paupers. The Board of Control also provided the service patient scheme in which they were not treated as paupers in asylums. Psychiatric doctors and the MPA saw these move as a new legitimacy for establishing long-cherished legislation for early treatment of mental disorders in non-asylum accommodation without legal certification.[110] Thus, the war reinforced the post-1890 rhetorical grounds of English psychiatry. Simultaneously, however, it brought an economic difficulty to psychiatry, because the Army and government introduced neurologists, experimental psychologists, and ordinary physicians who had treated mental and nervous cases, into military hospitals for nervous cases - milder mental cases - of soldiers. Consequently, psychiatrists had to compete with them in the market for milder and incipient cases of mental disease, the ones that English psychiatrists had insisted on having a monopoly over. Facing this new interprofessional competition, psychiatrists defended their own interests by emphasising their specialised knowledge against newcomers. Hence, the Great War changed the political economy of English psychiatry in the treatment of the mental disturbance; one change being for the good, the other prolonging the profession's difficulties.

[110] *Journal of Mental Science*, October, 1914, p. 668.

Chapter Six. The Political and Economic Struggle of the Psychiatric Profession in the 1920s

Introduction

Historians of English psychiatry have tended to argue that the 1920s were an important decade in the modernisation of provision, leading to the Mental Treatment Act of 1930. They considered it as important that a Royal Commission that was appointed in 1924 for new legislation with regard to lunacy and mental disorders, and that the Commission declared in its concluding report that the tone of mental health legislation should change from 'detention' to 'prevention and treatment.'[1] The notional shift from 'legalism' to therapeutic intervention led English psychiatry to new legislation in the form of the Mental Treatment Act of 1930.[2] Historians such as Kathleen Jones and Clive Unsworth have especially argued this narrative.[3]

Other historians have pointed to the fact that after the war, the London County Council officially opened the Maudsley Hospital for the treatment of incipient mental disease without legal certification, based on the London County Council (General Power) Act of 1915.[4] The Maudsley hospital was the most modern mental health institution in England and Wales, with its outpatient

[1] Report of the Royal Commission on Lunacy and Mental Disorder, H.M.S.O., 1926, p. 17.
[2] 20&21, Geo, 1930, Ch.23, p. 203-230.
[3] Kathleen Jones, *op.cit.*, 1993, pp. 135-136; Clive Unsworth, *op.cit.*, p. 171; pp. 202-203; p. 229.
[4] 5 & 6 Geo. V, 1915, Ch. 103 (*London County Council General Powers Act*).

department, teaching school, and research facilities.[5] These features were all requisites for early treatment of mental disorder. In addition, historians of psychology have noted that psychotherapeutic clinics were opened in the 1920s.[6]

This chapter reverses this historiography, by focusing on psychiatrists' political and economic strategies for monopolising the treatment of mental diseases. It argues that the political economy of English psychiatry had already been formulated between 1890 and the Great War. As previous chapters have demonstrated, the key was the 1890 Act that changed the personal and institutional economy of English psychiatry, with psychiatrists opposed to this Act mobilising to regain their economic interests through new rhetorical, personal and institutional strategies.

These are still observable in the 1920s. Indeed, they were the period when economic interests in psychiatry, which had been fermented between 1890 and 1918, were practically implemented. Thus, this chapter again pays attention to four major issues, the ones developed in the previous chapters: the political rhetoric of early treatment of mental disorder; the occupational structure of psychiatrists; voluntary admissions; and interprofessional competition for treatment of mental diseases. These have made this chapter a long and involved story, but were interconnected with each other. From these viewpoints, English psychiatry represents continuity, not discontinuity.

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[5] Kathleen Jones, *op.cit.*, 1993, pp. 126-127; Patricia Allderidge, 'The foundation of the Maudsley Hospital,' German E. Berrios, Hugh Freeman (eds), *op.cit.*, 1991, pp. 79-88; David Cochrane, '"Humane, economical, and medically wise": the LCC as administrators of Victorian lunacy policy,' Bill Bynum, Roy Porter and Michael Shepherd, *op.cit.*, 1988, pp.247-296; Edgar Jones, Shahina Rahman and Robin Woolven, 'The Maudsley Hospital: design and strategic direction, 1923-1939,' *Medical History*, 2007, pp. 357-378.

[6] Malcom Pines, 'The development of the psychodynamic movement,' German E. Berrios, Hugh Freeman (eds), *op.cit.*, 1991, pp. 206-231; Suzanne Raitt, *op.cit.*, p. 71.

1. The Political Economy of 'Early Treatment of Mental Disorder' in the 1920s

Board of Control and the Early Treatment of Mental Diseases, 1918-1922

After the Great War, the Board of Control led the political campaign for psychiatry. Its principal idea was similar to that of pre-war psychiatrists. Identifying the stigma of legal certification as 'a hindrance to the early treatment of mental diseases,' it argued that the legal stigma kept patients away from psychiatric treatment in the early stages of disease. Such patients eventually suffered both from chronic insanity and from the stigmatisation of legal certification.[7] To rectify this problem, the Board suggested that incipient cases of mental disorder receive 'treatment in general or special hospitals, mental institutions, nursing homes, or elsewhere, for limited periods, say six months, without necessity for certification under the Lunacy Acts.'[8] In particular, it recommended that such general hospital treatment be encouraged with the use of out-patient clinics, and that voluntary admission be applied to public asylums.[9] These measures were almost the same as psychiatrists had insisted in the pre-war period. In the words of the Board, however, the project focused on 'the health and welfare of the people.'[10]

This increasing role of the Board of Control resulted from the Mental Deficiency Act of 1913 that changed the Board's role from a watchdog body of mental health administration to that of a welfare authority in charge of people's mental health.[11] In the 1920s, such an ideal was understood not only by medical

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[7] *Annual Report of the Board of Control,* 1918, p. 2.
[8] *Ibid.*, p. 5.
[9] *Ibid.*
[10] *Ibid.*, 1920, p. 2.
[11] HL/PO/JO/10/10/759 (Parliamentary Archives).

commissioners, but also by legal commissioners.[12] Along with this notional change, importantly, the Board of Control transferred its supervising body from the Home Office to the Ministry of Health due to the enactment of the Ministry of Health Act of 1919.[13] With the Ministry, it began collaborating in its political campaign for amendment of the 1890 Act.[14]

Receiving the recommendation of the Board of Control, on 16 August 1920, Christopher Addison's Ministry of Health introduced in the House of Commons a bill for the early treatment of mental disorder: Ministry of Health (Miscellaneous Provisions) Bill of 1920.[15] Its Clause 10 aimed at 'treatment of mental disorder incipient in character, including shell shock cases, without legal certification.'[16] The bill reflected the problem in shell-shocked patients; Christopher Addison (1869-1951) stated in the Commons that it was crucial that shell-shocked soldiers 'should escape the stigma and disabilities of being classed as lunatics.'[17]

This was the first attempt to establish the idea of early treatment after the war. But it might be simply political performance of that medical statesman; if Addison had wanted to get it passed into law, he have had to take steps before December. The bill was introduced in, and passed through, the Commons with minor amendments in early December, but it was withdrawn at its second reading in the House of Lords on 14 December.[18] Psychiatrists were relieved rather than

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[12] For example, A. H. Trevor, the Barrister at Law and the Commissioner of the Board of Control, led a campaign for the Mental Treatment Bill of 1923 (*Transactions of the Medico-Legal Society*, 1923, pp. 181-192).
[13] 9 & 10 Geo. V, 1919, Ch. 21.
[14] *Annual Report of the Board of Control,* 1921, p. 1.
[15] *Journal of the House of Commons*, Vol. 175, 1920, p. 381.
[16] Ministry of Health (Miscellaneous Provisions) Bill, *Public Bills*, Vol. 3, 1920.
[17] *Parliamentary Debates, House of Commons*, Vol. 172, 1920, p. 532; *Lancet*, November 13, 1920, p. 1025.
[18] *Journal of the House of Commons*, Vol. 175, p. 381; p. 465. The withdrawal was partly because of Clause 1 of compulsory hiring houses for the working class. It was thought financially burdensome by politicians (*Parliamentary Debates, House of Commons*, Vol. 172, 1920, pp. 1551-1602).

regretful.[19] The MPA stated that 'the Association would rather have the clause dropped entirely than that it should become law without the emendation it had urged...we would rather have no change at all than one in the wrong direction.'[20] The misdirection was that psychiatrists would not get enough patients through the 1920 bill,[21] because its Clause 10 excluded from targets for early treatment 'people who had previously been in an asylum' and 'those recent cases who were unable to give consent and who should be treated if possible without being certified under the Lunacy Acts.'[22] The bill prevented psychiatrists from dealing with previously treated and new non-volitional cases of mental diseases, the large part of the mental health populations.

MPA's complaint did not extend to the partial preventive treatment for mental diseases incorporated by the 1920 bill. Rather, it was based upon the MPA's advocacy of 'wide and varied liberty of choice' of mental health provisions.[23] Under this principle, they said, psychiatrists would not 'recommend a patient to avail himself of any place of treatment which did not adopt one or other of the provisions, and there would be no necessary hardship to the patient in so doing, and consequently no reputable person proposing to receive patients in his house would attempt to evade such provisions.'[24] The free choice of treatment, as exercised in other branches of medicine, was the cherished demand of English psychiatrists. To accomplish it, they stressed their extreme self-confidence on their ethical code.

Despite the failure of the 1920 bill, the Board of Control continued to develop its political campaign. On 19 and 20 January 1922, it hosted a conference

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[19] *Journal of Mental Science*, January 1921, p. 55.
[20] *Ibid.*
[21] *Ibid.*, p. 125.
[22] *Ibid.*
[23] *Journal of Mental Science*, July 1920, p. 338.
[24] *Ibid.*, p. 340.

on lunacy administration, gathering various representatives from local authorities, local magistrates, psychiatrists, general physicians and surgeons. This conference was expected to be a place 'to consider in what directions Lunacy Administration and the treatment of the persons suffering from mental disease may be improved.'[25]

The specific focus was upon early treatment of mental disorders without certification at mental and general hospitals. The discussion was initiated by three medical superintendents of the public mental health hospitals: Edwin Goodall (1863-1944) at the Cardiff Mental Hospital, J. Shaw Bolton (1867-1946) at the West Riding Mental Hospital, and Thomas Saxty Good (-1945) at the Oxford City and County Mental Hospital.[26] Their rhetorical strategy was not new at all. The typical emphasis was on general hospital psychiatry and voluntary admission. Good emphasised the preventive value of the early treatment of mental disorders that would be provided by accommodation in general hospitals, since they were more

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[25] *Report of the Proceedings of the Conference convened by Sir Frederick Willis, Chairman of the Board of Control between Commissioners of the Board and Medical Superintendents and Chairman of Visiting Committees of County and Borough Mental Hospitals, and Medical Superintendents and Chairmen of Managing Committees of Registered Mental Hospitals, and certain others*, H.M.S.O., 1922.

[26] Edwin Goodall was born in Calcutta, the son of a solicitor. He was educated at Guy's Hospital, and appointed as a junior doctor at the hospital, Bethlem Royal Hospital and West Riding Hospital at Wakefield. His career path was extraordinarily successful. In 1906, he became superintendent at the Cardiff City Mental Hospital, where he promoted psychiatric researches closely related to general medicine. He was also an important advocate for the early treatment of mental disorder; it is observable in the fact that he served as physician to a psychiatric outpatient department in the Cardiff Royal Infirmary (G. H. Brown (ed.), *op.cit.*, pp. 449-450). Joseph Shaw Bolton was originally an unqualified assistant at an asylum in Whitby. He studied medicine at the University College London, winning a fold medal when graduating. He participated in asylum works at the London County Council's Claybury Asylum. In this asylum he played an important position of pathologist; the institution set pathological research as its primary aim. Because of this career, he could become the director of the West Riding Mental Hospital at Wakefield in 1910, and later held the chair of mental diseases at Leeds University (G. H. Brown (ed.), *op.cit.*, p. 500). Thomas Saxty Good was qualified in 1893 at St. George's Hospital and engaged in asylum works at the Oxford City and County Mental Hospital until 1936 when he retired. In his thirty-years services, he was known for starting an outpatient clinic at the Radcliffe Infirmary in Oxford in 1918, in which patients were treated without legal certification. In this sense, he was a practicing doctor of the early treatment of mental disorder in the 1920s. After retiring from asylum works, he spent much hours on private practices, and took initiatives in psychiatric politics until the end of the Second World War (*Lancet*, November 17, 1945, p. 654).

'get-at-able' than mental hospitals.[27] For the same reason, other doctors insisted that the voluntary boarder system was invaluable, because patients would not hesitate to submit themselves to psychiatrists' treatment before they became so ill as to be certifiable.[28]

This usual expression of the early treatment of mental disorder was received cheerfully by lay audiences at the conference. In the opening speech, Alfred Mond (1868-1930), the Minister of Health said that:

> It would be perfectly unfair to brand this great service with the stigma of any kind of callousness or cruelty. (hear, hear) In fact, the whole feeling of stigma ought to disappear; and the more we can do to equip our institutions so that every patient has the best chances of recovery, and the more the public realize that this is our aim, the sooner the stigma will be removed. (hear, hear) There is no more stigma about people having mental disease than about their having any other kind of disease-(hear, hear); that is what science is teaching us, and it is not realised what a large percentage are cured and discharged and become normal citizens again.[29]

Mond was followed by the representatives from local authorities. Four chairmen of the local asylum committee accepted the psychiatrists' assertions. To them, the preventive value of early treatment seemed attractive, because it would decrease financial burdens in the local authorities. Welcoming preventive treatment of mental diseases, George Wyatt Truscott (1857-1941), the Chairman of the City of London Mental Hospital Visiting Committee, remarked that 'what we want now to aim at is less law and more medicine.'[30]

Other audiences were also of the opinion that parliamentary powers should be granted in favour of the early treatment of mental disorder without certification,

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[27] *Report of the Proceedings of the Conference convened by Sir Frederick Willis,* p. 10.
[28] *Ibid.,* pp. 37-40.
[29] *Ibid.*, p. 5. As for Alfred Moritz Mond, see *Oxford DNB.*
[30] *Report of the Proceedings of the Conference convened by Sir Frederick Willis,* p. 15. With regard to George Wyatt Truscott, see *Times*, April 18, 1941, p. 9.

although some of the local authorities cast doubt on the available finances for establishing outpatient clinics.[31] After the conference, a member of the managing committee of the Holloway Sanatorium remarked that:

> The point of most general interest which was discussed was that of early treatment (in-patients and out-patients) without certification at mental hospitals and general hospitals. There was general agreement that mental cases should be treated at an early stage. ... It is satisfactory to state that the Conference agreed by a large majority that the approval and supervision of places for the early treatment of cases without certification should be by the Board of Control.[32]

From the public side, *The Times* referred to the 1922 conference in an article on the 'Stigma of Lunacy.' It stated that 'it was unfair to brand the asylum service with any stigma, and the whole feeling of stigma in regard to lunacy should disappear. The public did not realize how many patients were cured and discharged from asylums and returned to their normal life as good citizens, and it was important that the cloud of hopelessness in these cases should be lifted.'[33] Psychiatrists seemed to have wide public support for early treatment of mental disorder.

Referring to the early treatment idea, importantly, psychiatrists often defended their economic interests in the mental health jurisdiction. For example, they emphatically proposed that they be the supervisors of early treatment, by demanding positions at outpatient clinics at general hospitals that would provide preventive treatment without legal certification. At the 1922 conference, Good remarked that 'the man who takes that post [doctor in charge of an outpatient clinic] in a general hospital should be a man of our specialty.'[34] This seems related to his

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[31] *Report of the Proceedings of the Conference convened by Sir Frederick Willis,* p. 19. Also see *Annual Report of the Board of Control,* 1923, pp. 1-2.
[32] 2620/1/8 (Holloway Sanatorium Papers, Surrey History Centre).
[33] *Times*, January 20, 1922, p. 12.
[34] *Report of the Proceedings of the Conference convened by Sir Frederick Willis,* p. 10.

career path, since he was medical superintendent of a public asylum, which was usually a career step to such a privileged position in the private sector as a mental consultant.

The other economic complaint was about the restriction on private psychiatric admissions that the 1890 Act had caused. In giving a lecture at the Mental Welfare Associations in October 1922, John Robert Lord (1874-1931),[35] medical superintendent of the London County Council Mental Hospital at Bexley, manifested his dissatisfaction with the length of a patient's stay at asylums as limited by the 1890 Act. In particular, he criticised the urgency order with which psychiatrists could receive patients, whose symptoms necessitated immediate treatment, only within seven days, and the trial of absence system in which certified patients were allowed to leave the institution for convalescence.[36] These legal restrictions, Lord argued, interfered with psychiatric practice. This seems illogical because, in contrast to Lord's advocacy of early treatment, he wished to abolish safeguards against wrongful and prolonged detention of private patients. On this basis, he demanded a free market in mental health care in which no legislative restrictions were imposed on the management of any institutions either for charity or profit.[37] Insisting on the necessity of prevention and humanitarianism in mental health provisions, English psychiatrists also persisted their economic interests.[38]

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[35] John Robert Lord was from a family of the middle or upper working class in Blackburn. After being educated at a grammar school and the Owen College, he studied medicine at the Edinburgh University where he qualified. In 1897 he became staff of the Carmarthen Mental Hospital, and afterwards obtained positions in London County Council's asylums, such as Hanwell, Bexley and Horton where he became finally medical superintendent (*Lancet*, August 15, 1931, pp. 378-379).
[36] *Journal of Mental Science*, January 1923, pp. 156-157.
[37] *Ibid.*
[38] Mathew Thomson highlights that J. R. Lord was the psychiatrist who strove to enhance the scientific credentials of psychiatry, by increasing volume of research papers in the *Journal of Mental Science* and promoting a system of community care and psychiatric social workers (Mathew Thomson, *op.cit.*, 1998, p. 126; p. 145-146).

A Regrettable Challenge, 1923

Also in 1923, psychiatrists attempted to introduce an amendment bill to the 1890 Act. The 1923 campaign had the broadest range of political support from physicians, medical journals,[39] central health authorities, local authorities and the legal profession. Hence, psychiatrists did not have to push the idea of early treatment necessarily by themselves. However, this would not mean that psychiatrists' economic interest was not crucial in making psychiatry policies. Rather, importantly, statesmen, bureaucrats and non-psychiatric professional groups, having different motives, consequently drew up the policies that guaranteed psychiatrists' interests, whether consciously or unconsciously.

Although the press remained suspicious that psychiatrists would undermine the liberty of the English subject,[40] they followed the line set by psychiatrists and the Board of Control.[41] In the early part of the year, the *British Medical Journal* and *The Lancet* proposed a further attempt to establish new legislation that followed Clause 10 of the 'ill-fated' Ministry of Health (Miscellaneous Provisions) Bill.[42]

Receiving these messages, the legal commissioners of the Board of Control engaged positively in the promotion of early treatment. At the Medico-Legal Society, in May, A. H. Trevor (1858-1924), the Legal Commissioner of the Board of Control, read a paper on the coming amendment bill of the Lunacy Act of 1890. In this, Trevor reiterated the importance of early treatment of mental diseases, employing the psychiatrists' humanitarian rhetoric.[43] He remarked that it was unnecessary to attach the stigma of certification to mental patients who were

[39] For example, *British Medical Journal*, May 10, 1923, p. 431.
[40] *Ibid.*, May 26, 1923, pp. 915-916.
[41] *Lancet,* October 20, 1923, p. 872.
[42] *British Medical Journal*, February 24, 1923, p. 343; *Lancet*, February 17, 1923, p. 350.
[43] As for A. H. Trevor, see *Times*, October 2, 1924, p. 17.

temporarily unbalanced and only suffering from the disease, before they could receive the skilled treatment of psychiatrists.[44] In so saying, he concluded that it was the time for the amendment, since the war had opened the eyes of the public.[45] His paper was received warmly by both the medical and legal professions.[46]

After this success, the Medico-Legal Society drafted a new bill, and in April 1923, the Mental Treatment Bill was introduced by Earl Russell into the House of Lords.[47] Its chief purpose was still on the same lines: to enable patients suffering from incipient mental disorder to enter mental health institutions or general hospitals without the stigma of legal certification.[48] The bill also met psychiatrists' demands for the extension of non-certifying treatment to 'non-volitional' and previously admitted cases, which would lead to the free market of psychiatry.[49]

In the parliamentary proceedings, Earl Russell supported the bill sympathetically. In particular, he convinced Earl Onslow (1876-1945) of the necessity of early treatment of mental disease in order to progress the bill to the second reading.[50] He also, at the Medico-Legal Society in 1923, lashed out at the opponents of the bill. He said that:

> I have listened to the last speaker with some surprise, and I cannot help feeling that he can hardly have read the bill. If language means anything, I should have said that this bill involved a considerable change in the lunacy law, and not merely a change in terms, but a change in policy...it [the bill] begins by providing treatment in the earlier stages in the hope...of avoiding the necessity of at any time for certification, and of avoiding insanity altogether.[51]

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[44] *Transactions of the Medico-Legal Society*, 1923, p. 182.
[45] *Ibid.*, p. 184.
[46] *Ibid.*, pp. 204-205.
[47] *Ibid*, p. 181.
[48] 13 and 14 Geo. V, *Public Bills*, Vol. 2, 1923, pp. 1-4.
[49] *Ibid.*
[50] *British Medical Journal*, June 9, 1923, p. 990.
[51] *Transactions of Medico-Legal Society*, 1923, pp. 206-207.

His enthusiasm was invaluable help to the psychiatrists' campaign.

Because of its wide support in 1923, the bill seemed to psychiatrists to be a sure thing. At the annual party of the MPA in 1923, John George Porter Phillips (1877-1946), physician superintendent at the Bethlem Royal Hospital, presented a paper entitled 'Early Treatment of Mental Disorder.'[52] In this, he did not refer to such detailed supporting facts as actual curability of incipient mental cases. Instead, he reiterated the thesis of early treatment, using such phrases as 'as psychologists understand' and 'it is well known.'[53] Despite few references to the actual effect of early treatment itself, he emphasized its preventive and humanitarian importance. As supposed, his wish was to establish outpatient clinics in general hospitals and to extend voluntary admission.[54]

Following Phillips' talk, the politicians who had been invited to the meeting encouraged psychiatrists to establish new legislation. Eric Geddes (1875-1937), an ex-member of Parliament, remarked that:

> Men and women would talk of many illnesses to which man was subject with a notable frankness and openness, but in speaking of those afflicted with insanity the voice was lowered, and it was not thought considerate to the feelings of the relatives to inquire after the progress of the patient. This atmosphere of secrecy, obscurity, and shame was...one of the greatest unscientific barriers in the progress of the care of mental disorders. The public shrank from the "stigma of insanity" because it was less educated on this subject, which was surrounded with greater frankness.[55]

Following Geddes, Earl Onslow expressed his wishful thinking to psychiatrists that:

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[52] John George Porter-Phillips was educated at the University College London and Guy's Hospital in which he was qualified in 1907. Soon after this, he was appointed as junior physician at the Bethlem Royal Hospital and served for this hospital for thirty years, including his appointment as physician superintendent from 1914. He was also lecturer and physician for mental diseases at St. Bartholomew's Hospital, physician to the Hospital for Nervous Diseases at Lambeth, lecturer on mental pathology at the London School of Medicine for Women (G. H. Brown (ed.), *op.cit.*, p. 582)
[53] *Lancet*, October 20, 1923, p. 871.
[54] *Ibid.*, p. 873.
[55] *Journal of Mental Science*, October 1923, Vol. 69, pp. 562-563. The biography of Eric Geddes is available in *Oxford DNB and Times*, June 23, 1937, p. 16.

> As the law stands at present, it is very difficult to do anything for anybody who is suffering from mental disease without certification. This bill proposes to give people their chance, especially poor people, who cannot afford to be treated voluntarily. Thus, if this bill becomes law-and I think there is every prospect of it becoming law by the end of this year.[56]

As a result, Earl Onslow was lauded by psychiatrists.[57] It was deemed a truly exciting moment by English psychiatrists who long cherished amendment to the 1890 Act.

But the 1923 bill failed to be enacted. Although the House of Lords passed the bill in June, the Commons adjourned it at the second reading thirteen times.[58] In the autumn, the Commons was dissolved before the end of the session. As a result, the 1923 bill was kept in the second reading stage for five months and then withdrawn. The Commons never discussed it.

Psychiatric Altruism in the Royal Commission, 1924-26

After the failure of the Mental Treatment Bill of 1923, English psychiatrists had another opportunity to challenge the 1890 legislation: the Royal Commission on Lunacy and Mental Disorder which was appointed in 1924. The Commission was derived not from the psychiatrists, but from the Ministry of Health after an inquiry into Montague Lomax's book critical of asylums.[59] Lomax's book was disputed by psychiatrists, since he revealed institutional abuses and ill-treatment conducted by

[56] *Journal of Mental Science*, October 1923, pp. 562-563.
[57] *Ibid.*
[58] *Journals of the House of Commons*, Vol. 178, 1923.
[59] Kathleen Jones, *op.cit.*, 1993, pp. 130-131.

asylum doctors and workers. Inasmuch as his criticism led to a Royal Commission, however, his disclosures advantaged the politics of psychiatry.[60]

At the Royal Commission, psychiatrists reiterated the thesis of early treatment of mental disorder, as usual. Their rhetorical emphasis was also the same, namely, the harmful consequences of legal certification from the viewpoint of humanitarianism. The delegates sent by the MPA raised 57 recommendations that were mainly related to treatment without legal certification, specifically to general hospital psychiatry and voluntary admissions.[61] In doing so, MPA psychiatrists attacked the stigma of legal certification. Because of the stigma, patients who had been discharged from an asylum were forced into unemployment, the MPA insisted. Employers often said that, 'he may have a relapse at any time: he might have one now.'[62]

Henry Devine (1879-1940), medical superintendent of the Portsmouth Mental Hospital, impressed the Commission's members with his altruistic attitude to stigmatised lunatics.[63] In responding to the question of if, in his experience, the legal certification was regarded as a slur upon a patient's reputation, Devine answered that:

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[60] Montague Lomax, *The experiences of an asylum doctor: with suggestions for asylum and lunacy law reform*, London, 1921. Also see T.W. Harding, ' "Not worth powder and shot": a reappraisal of Montague Lomax's contribution to mental health reform,' *British Journal of Psychiatry*, Vol. 156, 1990, pp. 180-187.

[61] *Minutes of evidence taken before the Royal Commission on Lunacy and Mental Disorder*, 1926, pp. 960-966.

[62] *Ibid.*

[63] Henry Devine was from a family of a postmaster at Colchester. He studied medicine at the University College, Bristol and qualified in 1902. After having experienced junior hospital appointments in England and the continent, he joined asylum works at the West Riding Asylum at Wakefield, and later had junior posts at the Cane Hill Asylum and Long Grove Asylum, both of which were run by the London County Council. Interrupted by the Great War in which he served as consulting psychiatrist to the Royal Victoria Hospital at Netly, he obtained a position for the superintendence of the Portsmouth Corporation Mental Hospital and Holloway Sanatorium in which he retired in 1938 (G. H. Brown (ed.), *op.cit.*, pp. 563-564).

> It is a very serious slur; it is irrational that it should be so, but it is. If a patient is certified, not only is that patient subjected to a very insidious and unpleasant social censorship hereafter, but the children are as well. I see it repeatedly. Take the case of a woman who is certified for puerperal insanity. I can think of a case at the moment in which the children have been brought up with everyone round them watching every mortal movement they make, and finding evidence of abnormality, creating neurosis.[64]

As Robert Armstrong-Jones had done previously, Devine stressed the inhumane effect of legal certification as exemplified in the cases of puerperal insanity. Through legal certification, Devine insisted, local people would humiliate both mothers and children. This typically sentimental rhetoric - women and children - was used for developing psychiatric humanitarianism. Likewise, other psychiatrists expressed the same view on certification and its stigma, thereby advocating deregulation of voluntary admission and establishment of general hospital psychiatry.[65] The model institutions were the outpatient clinic run jointly by St. Luke's Hospital for Mental Diseases and the Middlesex Hospital, the Lady Chichester Hospital at Brighton and the Maudsley Hospital.

Not only psychiatrists, but poor law doctors and administrators agreed with Devine. Arthur Lionel Baly (1880-1933), medical superintendent of the Lambeth Poor Law Infirmary, remarked that 'there is the tremendous advantage...of removing stigma of the certificate. From what I can judge from the attitude of friends, that is very real, and if you cannot remove that stigma, no reform is likely to meet the desire of the public, as I see the public - the friends of the patients.'[66] The

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[64] *Minutes of evidence taken before the Royal Commission on Lunacy and Mental Disorder*, 1926, p. 173.

[65] They were J. Francis Dixon, medical superintendent of the Humberstone City Mental Hospital, O.G. Connell, medical superintendent of the Norfolk Mental Hospital at Thorpe, and H. Wolseley-Lewis, medical superintendent of the Kent County Mental Hospital at Maidstone (*Ibid.*, p. 156; pp. 160-162; pp. 183-184).

[66] *Ibid.*, pp. 109-110. Regarding Arthur Lionel Baly, see *Times*, November 1, 1933, p. 7.

other poor-law administrators were of the same opinion.[67] In the words of one non-psychiatrist, the abolition of legal certification should be a public demand.[68] Additional support for English psychiatry came from the medical profession and local and governmental authorities at the Commission: the BMA,[69] Scottish psychiatrists,[70] physicians interested in mental hygiene,[71] Board of Control,[72] Ministry of Health, the National Asylum Workers' Union,[73] London County Council administrators,[74] and the Association of Municipal Corporations. Most of these witnesses, whether medical or not, advocated the early treatment of mental disease without legal certification on grounds of humanitarianism. Even the National Society for Lunacy Reform, an anti-asylum voluntary organisation, advocated the early treatment principle.[75]

Considering the wide support for early treatment, the Royal Commission declared in its report that 'the keynote of the past has been detention; the keynote of the future should be prevention and treatment,' and called for 'the eradication of old-established prejudices and a complete revision of the attitude of society in the matter of its duty to the mentally afflicted.'[76] In particular, its focus was on the current situation in which 'the mental patient is not admissible to most of the institutions provided for his treatment until his disease has progressed so far that he has become

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[67] For example, J. Dudgeon Giles, medical superintendent of the Salford Union Infirmary, Harold Senior, the president of the National Association of Masters and Matrons of Poor-Law Institutions, and Rev. P.S.G. Propert, the President of the Association of Poor-Law Unions (*Ibid.*, pp. 117-118; pp. 127-128; pp. 243-248).
[68] *Minutes of evidence taken before the Royal Commission on Lunacy and Mental Disorder*, p. 173. Maurice Craig also referred to the stigma of certification in the Commission (*Ibid.*, p. 904).
[69] *Ibid.*, pp. 952-959.
[70] *Ibid.*, pp. 666-673; p. 691; p. 753.
[71] *Ibid.*, pp. 746-753.
[72] *Ibid.*, p. 26.
[73] *Ibid.*, pp. 525-530.
[74] *Ibid.*, p. 829.
[75] *Ibid.*, pp. 422-433.
[76] *Report of the Royal Commission on Lunacy and Mental Disorder*, 1926, p. 17.

a certifiable lunatic. Then and then only is he eligible for treatment.'[77] As psychiatrists saw it, the Commission considered that the delay in treatment was caused by the legal certification, because it carried a stigma to the public mind.[78] Supporting the psychiatrists' interests wholesale, the Commission's final report recommended the new measure of early treatment without certification. [79]

This was to some extent an expected result, because the Commission consisted mostly of Labour members and medical commissioners. Among the ten commissioners, six were members or sympathisers with Labour, and two were doctors.[80] Only one was a Conservative lawyer. Thus, it was not difficult for them to accept the early treatment thesis that highlighted its value to people's health and respectability.

English psychiatrists received the report of the Royal Commission warmly. In January 1926, the MPA showed its satisfaction with 'the abolition of the many anomalies and the relaxations of the legal restrictions which had for nearly a century handicapped the progress of psychiatry in England and Wales,' thereby expressing its satisfaction as 'triumph.'[81] This triumph meant that:

> The traditional supremacy of the legal and detention viewpoint would receive a set-back, and mental therapeutics would be given more freedom of action, especially in the care and treatment of mental disorders in their early stages.[82]

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[77] *Ibid.*, pp. 18-19.
[78] *Ibid.*, p. 43.
[79] *Ibid.*, p. 49.
[80] On the Labour side, there were Hugh Pattison Macmillan (1873-1952), the Lord Advocate of the Labour Government, William Allen Jowitt (1885-1957), former Labour MP temporarily losing his seat in 1924, Henry Snell (1865-1944), Labour MP, Madeleine Jane Robinson (1896-1957), a social campaigner for women workers, and Earl Russell (*DNB*; *Times*, March 22, 1957, p. 10). Medical commissioners were Humphry Davy Rolleston (1862-1944), physician and neurologist to St. George's Hospital, and David Drummond (1852-1932), Professor of Medicine of the Durham College of Medicine (*DNB*; *Times*, April 29, 1932, p. 19).
[81] *Journal of Mental Science*, January, 1926, pp. 597-598.
[82] *Ibid.*

Psychiatrists had only a relatively minor but important complaint about the report. It was that the Commission did not reflect one of the recommendations of the MPA that non-volitional cases be allowed access to early treatment without legal certification. As with the 1920 bill, the Commission allowed only minor cases to be treated in psychiatric clinics, nursing homes and in single care without legal certification.[83] Under the scheme, psychiatrists could exercise very limited liberty in providing treatment. On the surface, the Royal Commission seemed successful for psychiatrists, but it left an important economic issue unsolved.

The Last Challenge, 1929-1930

Based on the report of the Royal Commission, Earl Russell, in early 1929, introduced a bill to amend the 1890 Act into the House of Lords with the support of the Ministry of Health and Labour government.[84] It was the ninth challenge since the first bill of 1897, so that it was no longer impressive that the Minister of Health advocated early treatment of mental disorders, criticising the 'stigma of certification' in Parliament.[85]

Despite the recommendation of the Royal Commission, the 1929 bill did meet psychiatrists' demands for admission systems without legal certification not only for voluntary cases but for non-volitional cases.[86] Through this, psychiatrists became able to provide their treatment and care for most patients without legal checks. Although not allowing doctors to establish new private asylums, it gave the

[83] *Ibid.*, p. 613. Similar opinion was stated by Reginald Langdon-Down on November 8, 1927 (*Ibid.*, January 1928, pp. 35-37).
[84] *Journals of the House of Commons*, Vol. 185, p. 144.
[85] *Lancet*, February 22, 1930, p. 433.
[86] See Clause 1, 2 and 3 of the Mental Treatment Act of 1930 (20 & 21 Geo. 5).

power of providing treatment for voluntary and non-volitional patients without legal certification at 'any hospitals, nursing home or place approved' in the name of preventive and humanitarian medicine.[87] The approved place meant that psychiatrists could open private premises for such mild cases with the permission of the Board of Control. The Parliamentary Committee of the MPA showed its satisfaction with the extensive bill that would open the closed private market of psychiatry.[88]

Although the bill of 1923 was withdrawn after a long adjournment, the 1929 bill was committed to a standing committee soon after its introduction. It passed through the Lords in the middle of May without any major amendments. In the Commons, however, four amendments were made. But these did not cause any major change to its original suggestions especially as to the treatment for non-volitional cases and the extension of private treatment to 'approved homes.'

These successful proceedings were because the Labour Party, the majority party at the session, was supportive of the bill. In particular, Arthur Greenwood (1880-1954),[89] the Minister of Health, and Arabella Susan Lawrence (1871-1947), [90] the Parliamentary Secretary for the Minister, represented well the recommendations of the Royal Commission on Lunacy and Mental Disorder.[91] Lawrence especially applied her militant attitudes to the member who opposed to the bill.[92]

Many of the medical and Labour Members of Parliament welcomed the 1929 bill: notably, Robert Forgan (1891-1976), Labour MP for West Renfrewshire,[93]

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[87] *Ibid.*
[88] *Journal of Mental Science*, April 1930, pp. 324-326.
[89] *DNB.*
[90] *Ibid.*
[91] *Parliamentary Debates, House of Commons*, Vol. 235, 1930, pp. 957-964.
[92] *Ibid*, Vol. 237, 1930, pp. 2571-2572.
[93] *Times*, January 16, 1976, p. 16.

Francis Fremantle (1872-1976), Conservative MP for St. Albans,[94] Ethel Bentham (1861-1931), Labour MP for Islington East,[95] Somerville Hastings, Labour MP for Reading,[96] John Kinley (1878-1957), MP for Bootle and William John Brown (1895-1960), MP for Newbury.[97] Their concerns were primarily with the public health of the working class. Hence, they concentrated on the provision for the working class in the hope that they would be no longer certified and would be definitely treated as possibly curable cases.[98] Henry Morris-Jones (1884-1972), Labour MP for Denbigh and a general practitioner, remarked that 'if they are rich there are, of course, plenty of private establishments where they can go. If they are poor, they are the very class you want to cater for. If they can go quietly, without any stigma or curiosity, and secure treatment at an early stage, they will probably never become certifiably insane persons at all.'[99] Such support to the bill was often called 'enthusiastic' in the Commons. [100]

Only a few Conservatives advocated the 1929 bill: George Douglas Cochrane Newton (1879-1942), Conservative MP for Cambridge,[101] Derrick Gunston (1891-1985), Conservative MP for Thornbury, Sir Kingsley Wood (1881-1943), Ex-Parliamentary Secretary for the Minister of Health in the Conservative government.[102] Among them, Wood joined discussions to assist the bill. He thought that the 1890 Act was an old-fashioned obstacle to the progress of psychiatry. Quoting a letter, he told in the Commons that:

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[94] *Ibid.*, August 28, 1943, p. 7.
[95] *Oxford DNB.*
[96] *Times*, July 8, 1967, p. 12.
[97] *Ibid.*, October 5, 1960, p. 15.
[98] *Parliamentary Debates*, House of Commons, Vol. 235, 1930, p. 966.
[99] *Ibid.*, p. 16.
[100] *Ibid.*, p. 1053; p. 1065.
[101] *Times*, September 3, 1942, p. 7. Biographical information about Howard Kingsley Wood is taken from *Oxford DNB.*
[102] *Ibid.*

> My own wife had a breakdown six weeks after the birth of our little daughter, and we had to get her away at once to a private mental home. She was absolutely fit again in three weeks, yet to get her under proper care, she had to be certified by two doctors and a J.P. She did not know it, and I pray she never will, for the knowledge that she had once been certified as a lunatic would be enough to send her permanently insane.[103]

Such sympathetic opinion about mentally ill patients as Wood had, however, arose little from the Conservatives.

Oppositions came mainly from radical Labours and Independent Labours. In particular, Josiah Clement Wedgwood, the Independent Labour MP for Newcastle-under-Lyme,[104] and Jack Jones (1873-1941),[105] the Labour MP for Silverton, opposed the clauses related to non-certifying treatment of voluntary and non-volitional patients. They contended that asylums were not the proper sites for the treatment of mentally ill patients, even if early treatment was facilitated. They also claimed that Board of Control was a useless administrative body for safeguarding patients from wrongful certification.[106]

They were not necessarily opposed to the principle of early treatment of mental disorders. In the historiography, Wedgwood has been described as a politician who considered as important the liberty of English subjects rather than the therapeutic perspective of early treatment.[107] However, in fact, he believed the necessity of non-asylum treatment for mentally ill patients. In 1919, Wedgwood asked the Minister of Health whether the government would provide convalescent homes for early uncertifiable mental cases, which should be regarded as half-way

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[103] *Parliamentary Debates, House of Commons*, Vol. 235, 1930, p. 972.
[104] *Oxford DNB.*
[105] *Times*, November 22, 1941, p. 6.
[106] *Parliamentary Debates, House of Commons*, Vol. 237, 1930, pp. 2527-2528.
[107] Clive Unsworth, *op.cit.*, pp. 188-190. Mathew Thomson argues that up to the middle of 1920s, Wedgwood gradually lessened his libertarian concerns that he had in 1913 (Mathew Thomson, *op.cit.*, 1998, p. 56).

houses to asylums.[108] Hence, his complaint about the 1929 bill was that it still set asylums in the centre of the mental health provisions. Although new legislation was facilitated, he believed, asylums would be asylums, not hospitals. Hence, he argued that the 1929 bill was unnecessary, because without this legislative amendment, English people could have non-asylum and non-certifying treatment in private nursing homes.

On 10 July, the Mental Treatment Act was given Royal Assent.[109] The new Act won three important provisions. One related voluntary admissions in all mental health premises, including public mental hospitals and registered private nursing homes. More important was a temporary admission system in which mental institutions could receive patients, who were unwilling to be admitted to mental hospitals but supposedly curable in earlier stages of the diseases, for six months, which was extendable by the Board of Control to a maximum of 12 months. The application for this admission was to be produced by patients' relatives and duly authorised officers of the local authority with two medical 'recommendations,' not medical certificates. This was the non-certifying treatment for non-volitional cases that psychiatrists had cherished in the 1920s. The other legislative device was through empowerment of local authorities to provide psychiatric outpatient clinics to general hospitals. All of these measures were designed to enable psychiatrists to see incipient and milder cases without legal certification.[110]

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[108] *Parliamentary Debates, House of Commons*, Vol. 119, 1919, p. 205.
[109] *Journals of the House of Commons*, Vol.185, p. 441.
[110] 20&21, Geo, 1930, Ch.23, p. 203-230. Also see Kathleen Jones, *op.cit.*, 1993, pp. 135-136.

Behind the Triumph

Importantly, the 1930 Act was not simply a triumph of humanitarian and preventive psychiatry.[111] Behind its political claim for early treatment, the psychiatric profession demanded supremacy over the medical market for early and mild mental diseases and an extension of the boundary of its own provisions. In doing so, psychiatric doctors consistently pursued an admission system without legal certification for non-volitional patients. This was rather strange because such cases definitely had severe symptoms that could be rarely cured in the short term. It also seems dangerous to place unwilling patients at asylums in terms of human rights. For these discrepancies underlying the 1930 Act, psychiatrists rarely provided reasons. Hence, the early treatment for non-volitional cases was, in fact, simply treatment without legal supervision.

It is also to be noted that the 1930 Act followed psychiatrists' demands for the establishment of psychiatric departments at general hospitals. General hospital psychiatry was, as Chapter 2 and 3 have argued, a means for psychiatrists to create new appointments that would aid their consulting businesses. To monopolise these appointments, psychiatrists emphasised their specialty in mental disease in the 1920s, too.[112] And their wishes were in the end stipulated in the 1930 Act.

Importantly, the 1930 Act also allowed doctors to establish 'approved homes' for non-certifiable cases with the sanction of the Board of Control. This was based on the recommendations of the MPA and BMA for the Royal Commission on

[111] *Ibid*; Clive Unsworth, *op.cit.*, p. 171; pp. 202-203; p. 229.
[112] At the meeting of the Northern and Midland Division of the MPA, Mary R. Barkas, medical superintendent of The Lawn, a registered hospital at Lincoln, insisted that 'out-patient departments must be staffed by experienced psychiatrists, whether attached to general hospitals or separate clinics' (*Journal of Mental Science*, July, 1930, p. 591).

Lunacy and Mental Disorder in 1924.[113] Little attention has been paid to it by historians, or by contemporaries because of the strong argument of psychiatrists for humanitarianism and preventive medicine. However, the clause, in fact, enabled psychiatrists to run private institutions without legal control. Apart from the rhetorical surface, psychiatrists successfully revived the free economy in the private sector of psychiatry that was undermined by the 1890 Act, through the voluntary admission system, general hospital psychiatry, and privately running institutions.

[113] *Minutes of the Royal Commission on Lunacy and Mental Disorder*, 1926, p. 956; p. 964.

2. The Post-War Professional Structure of English Psychiatry

The Continuous Extension of Psychiatric Consulting Business

In the 1920s, the 1890 Act remained a substantial economic obstacle to the career paths of English psychiatrists. To remove this difficulty, they attempted to shift their political and economic centre from private asylums to consulting practices, as Chapter 3 has argued. In promoting this shift, they found usefulness in general hospital psychiatry which would increase hospital connections, an important requisite for successful consulting businesses. On these grounds, psychiatrists claimed the necessity for general hospital psychiatry to be incorporated into the 1930 Act. This argument draws from a statistical examination of the occupational structure of the psychiatric profession.

This section starts by showing the regional distribution of members of the MPA in Table 6-1. In this table, it can be seen that the MPA did not mark a substantial increase between 1914 and 1930, keeping almost the same regional distribution. This numerically unchanged profile can add support to this chapter's argument that the important structural changes of English psychiatry had already taken place in the pre-war period.

In England and Wales, too, the statistical profile of the MPA psychiatrists remained unchanged. Table 6-2 and 6-3 contribute to this view. They also document an increasing concentration on the London metropolitan area in 1930, a continuing trend from 1890.

Table 6-1. The Regional Distribution of the MPA Members, 1914 and 1930

	1914		1930		
	No.	Proportions to (A)	No.	Growth Rate	Proportions to (C)
Total	695 (A)		718 (C)	103.3%	
England & Wales	483	69.5%	508	105.2%	70.8%
Scotland	102	14.7%	100	98.0%	13.9%
Ireland	50	7.2%	47	94.0%	6.5%
Overseas	56	8.1%	63	112.5%	8.8%
Unidentified	4	0.6%	1	25.0%	0.1%

Sources: *Journal of Mental science*, Vol. 60, 1914, pp. i-xxix; *Ibid.*, Vol. 76, 1930, pp. xviii-xlviii.

Table 6-2. The Regional Distribution of the MPA Members in England and Wales, 1914 and 1930

	1914		1930		
	No.	Proportions to (A)	No.	Growth Rate	Proportions to (B)
Total	483 (A)		507 (B)	105.00%	
Metropolitan	115	23.80%	133	115.70%	26.20%
Province	368	76.20%	374	101.60%	73.80%

Sources: *Journal of Mental science*, Vol. 60, 1914, pp. i-xxix; *Ibid.*, Vol. 76, 1930, pp. xviii-xlviii.

Table 6-3. The Regional Distribution of Psychiatrists in England and Wales, 1914 and 1930

	1914		1930		
	No.	Proportions to (A)	No.	Growth Rate	Proportions to (B)
Total	418 (A)		451 (B)	107.89%	
Metropolitan	97	23.20%	111	114.43%	24.61%
Province	321	76.80%	340	105.92%	75.39%

Sources: *Journal of Mental science*, Vol. 60, 1914, pp. i-xxix; *Ibid.*, Vol. 76, 1930, pp. xviii-xlviii.

Behind this trend was the rise of psychiatric consultancy. While psychiatrists in England and Wales achieved only a ten percent increase between 1914 and 1930, psychiatric consultants and semi-consultants increased significantly. This is shown in Table 6-4 clearly. The population of consulting psychiatrists arose from 24 to 60 during the 40 years after the 1890 Act.

Table 6-4. The Internal Structure of English Psychiatrists, 1914 and 1930

	1914		1930		
	No.	Proportions to (A)	No.	Growth Rate	Proportions to (B)
Class [1] Consultant	**36**	**8.61%**	**60**	**166.67%**	**13.30%**
[1-A] Metropolitan	21	5.02%	29	138.10%	6.43%
[1-B] Province	15	3.59%	31	206.67%	6.87%
Class [2] Practitioner	**25**	**5.98%**	**26**	**104.00%**	**5.76%**
[2-A] Metropolitan	10	2.39%	10	100.00%	2.22%
[2-B] Province	15	3.59%	16	106.67%	3.55%
Class [3] Proprietor	**46**	**11.00%**	**43**	**93.48%**	**9.53%**
[3-A] Metropolitan	14	3.35%	14	100.00%	3.10%
[3-B] Province	32	7.66%	29	90.63%	6.43%
Class [4] MS Private	**20**	**4.78%**	**30**	**150.00%**	**6.65%**
[4-A] Metropolitan	3	0.72%	6	200.00%	1.33%
[4-B] Province	17	4.07%	24	141.18%	5.32%
Class [5] MS Public	**91**	**21.77%**	**94**	**103.30%**	**20.84%**
[5-A] Metropolitan	11	2.63%	13	118.18%	2.88%
[5-B] Province	80	19.14%	81	101.25%	17.96%
Class [6] Senior Asst	**57**	**13.64%**	**80**	**140.35%**	**17.74%**
[6-A] Private	5	1.20%	10	200.00%	2.22%
[6-B] Public	52	12.44%	70	134.62%	15.52%
Class [7] Asst	**100**	**23.92%**	**110**	**110.00%**	**24.39%**
[7-A] Private	28	6.70%	17	60.71%	3.77%
[7-B] Public	72	17.22%	93	129.17%	20.62%
Class [8] Retired	**14**	**3.35%**	**4**	**28.57%**	**0.89%**
Class [9] Others	**29**	**6.94%**	**4**	**13.79%**	**0.89%**
[9-A] Metropolitan	6	1.44%	1	16.67%	0.22%
[9-B] Province	23	5.50%	3	13.04%	0.67%
Total	**418**	**(A)**	**451 (B)**	**107.89%**	

Sources: *Journal of Mental science*, Vol. 60, 1914, pp. i-xxix; *Ibid.*, Vol. 76, 1930, pp. xviii-xlviii; *Medical Directory*, London: John Churchill and Sons, 1914; *Ibid.*, 1930.

Table 6-5. The Internal Structure of Senior English Psychiatrists, 1914 and 1930

	1914		1930		
	No.	Proportions to (A)	No.	Growth Rate	Proportions to (B)
Class [1] Consultant	**36**	**16.51%**	**60**	**166.67%**	**23.72%**
[1-A] Metropolitan	21	9.63%	29	138.10%	11.46%
[1-B] Province	15	6.88%	31	206.67%	12.25%
Class [2] Practitioner	**25**	**11.47%**	**26**	**104.00%**	**10.28%**
[2-A] Metropolitan	10	4.59%	10	100.00%	3.95%
[2-B] Province	15	6.88%	16	106.67%	6.32%
Class [3] Proprietor	**46**	**21.10%**	**43**	**93.48%**	**17.00%**
[3-A] Metropolitan	14	6.42%	14	100.00%	5.53%
[3-B] Province	32	14.68%	29	90.63%	11.46%
Class [4] MS Private	**20**	**9.17%**	**30**	**150.00%**	**11.86%**
[4-A] Metropolitan	3	1.38%	6	200.00%	2.37%
[4-B] Province	17	7.80%	24	141.18%	9.49%
Class [5] MS Public	**91**	**41.74%**	**94**	**103.30%**	**37.15%**
[5-A] Metropolitan	11	5.05%	13	118.18%	5.14%
[5-B] Province	80	36.70%	81	101.25%	32.02%
Total	**218**	**(A)**	**253 (B)**	**116.06%**	

Sources: *Journal of Mental science*, Vol. 60, 1914, pp. i-xxix; *Ibid.*, Vol. 76, 1930, pp. xviii-xlviii; *Medical Directory*, London: John Churchill and Sons, 1914; *Ibid.*, 1930.

Table 6-6. The Sectional Distribution of Senior English Psychiatrists, 1890 and 1914

	1914		1930		
	Number	Proportion to (A)	Number	Growth Rate	Proportion to (B)
Private Sector: Total	127	58.26%	159	125.20%	62.85%
Consultants/Practitioners	61	27.98%	86	140.98%	33.99%
Proprietors/Superintendents of private institutions	66	30.28%	73	110.61%	28.85%
Public Sector: Total	91	41.74%	94	103.30%	37.15%
Superintendents of public institutions	91	41.74%	94	103.30%	37.15%
Total	218 (A)		253 (B)	116.06%	

Sources: *Journal of Mental science*, Vol. 60, 1914, pp. i-xxix; *Ibid.*, Vol. 76, 1930, pp. xviii-xlviii; *Medical Directory,* London: John Churchill and Sons, 1914; Ibid., 1930.

The rise of mental consultants is observed more clearly in Table 6-5 and 6-6, which show the occupational hierarchy of senior psychiatrists. Between 1914 and 1930, the proportion of mental consultants and practitioners rose from 27.98 percent to 33.99 percent. Behind them were salaried psychiatrists. In particular, as shown in Table 6-6, the extension of the 'private practice psychiatry' is remarkable.

The mental consultants at the top of the pyramid structure of the psychiatric profession typically located their private offices in the area close to Cavendish Square and Harley Street in London, similar to other consulting doctors of medicine and surgery. By 1930, Bernard Hart,[114] J. F. Woods,[115] Henry Yellowlees (1888-1971)[116] and Doris Maude Odlum were settled at Harley Street; [117] John Carswell (1856-1931) at Montague Place;[118] Maurice Craig at Cambridge Gate; Theophilus Bulkeley Hyslop at Portland Street;[119] James Leitch Wilson at New Cavendish

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[114] Bernard Hart was educated at the University College Hospital and universities in Paris and Zurich. After having qualified, he joined the Hertfordshire County Asylum as assistant medical officer and later moved to the Long Grove Asylum. In the Great War, he obtained an opportunity to learn psychopathology at a military mental hospital at Maghull. Because of this, he was appointed as physician for psychological medicine at the University College Hospital. Through this position, he established his consulting practices (*Times*, March 17, 1966, p. 14).

[115] John Francis Woods began his career as resident attendant at a private asylum at Leyton, and later served as assistant medical officer of the Portsmouth Borough Asylum, Somerset County Council Asylum and St. Luke's Hospital. He spent his later career at the Hoxton House private asylum in London whereby he practiced as a consulting doctor at West End (*Medical Directory*, London: John Churchill and Sons, 1930, p. 361).

[116] Henry Yellowlees was the son of David Yellowlees, the superintendent of Glasgow Royal Asylum. He was educated at the Glasgow University where he qualified M.B. Influenced by his father, he began asylum works. He served as deputy superintendent at the Western Infirmary, Perth District Mental Hospital and Royal Edinburgh Hospital. Similar to other psychiatrists, he promoted his career in the Great War; he became lecturer in psychiatry at the University of Edinburgh, and in 1928 became physician for mental diseases at St. Thomas's Hospital (*Times*, April 8, 1971, p.16; *Lancet*, April 17, 1971, pp. 812-814). Through this general hospital's connection, he established his private practice.

[117] Doris Maude Odlum started her asylum work as assistant medical officer to the Camberwell House private asylum in London. She later became resident medical officer at the Lady Chichester Hospital, thereby being promoted to physician at a outpatient clinic for nervous disorders at the Victoria and Hants Hospital (*Medical Directory*, 1930, p. 243).

[118] John Carswell was an originally Glasgow-based alienist. He studied, qualified and worked at an asylum in Glasgow. He was also a Scottish advocate for the early treatment of mental disorder. He opened psychiatric wards in connection with poor-law and general hospitals in Glasgow, and became consultant physician to these. In the 1920s, he became resident in London practicing privately at West End (*Times*, June 22, 1931, p. 14).

[119] Theophilus Bulkeley Hyslop graduated from the University of Edinburgh and studied in London and Paris. After having been assistant medical officer of the West Riding Asylum at Wakefield, he

Street.[120] They were indeed elite psychiatric doctors in terms of money and status as well as political power.

In the post-war period, 'private practice psychiatry' spread into the relatively lower class of psychiatrists who had not experienced medical superintendence at mental health institutions. Instead of pursuing senior appointments at public mental hospitals, junior psychiatrists looked for opportunities to open private practices in the relatively earlier stages of their career. To do so, they obtained honorary appointments in local hospitals, as consulting psychiatrists had the positions of physicians and lecturers at major general hospitals. For example, Norah Annie Crow had a private practice at Brighton with the position of honourary assistant physician at the Lady Chichester Hospital.[121] Before doing so, she was house physician at the Royal Free Hospital and medical officer at the Lady Chichester Hospital for Nervous Diseases. Her honourary position seems minor but possibly very important for her to operate her private practice. Similarly, Ellis Stungo, who had been a salaried psychiatrist in a private asylum, became a practitioner at Southwark with a honourary position at the London Jewish Hospital.[122] After 1890, these career paths were no longer unique. Junior psychiatrists adopted a similar strategy to Harley Street mental consultants in the private sector that was restricted by the 1890 Act.

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had positions at the Royal Bethlem Hospital: clinical assistant, resident physician and physician superintendent. This privileged career at Bethlem led him to consulting practices at West End, with which he combined his hospital appointment at St. Mary's Hospital (*Times*, February 15, 1933, p.17).

[120] Before becoming a consultant at West End in London, James Leitch Wilson had been senior house surgeon to the Royal Infirmary at Bradford and assistant medical officer of the Brook House private asylum in London. In the Great War, he served as major in the Royal Army Medical Corps (*Medical Directory*, 1930, p. 357).

[121] *Ibid.*, p. 597.

[122] *Ibid.*, p. 317.

Economy of Private Asylums

The increase of private-practice psychiatry was inversely proportional to the decline of private asylums. This was obviously caused by the 1890 Act, because of its prohibition of the establishment of new private asylums. These traditional institutions were no longer promising job providers for psychiatrists. Also importantly, the existing private asylums gradually tended to limit their proprietorship within their connections. This monopoly of private asylums led, as Chapter 3 has argued, psychiatric doctors, who wished to have a more privileged professional life, to become consulting doctors or practitioners specialising in mental diseases.

The change in the psychiatric job market documents how profitable the private sector of psychiatry was, but the finance of private asylums has been relatively unknown especially in the early twentieth century. The Royal Commission on Lunacy and Mental Disorders revealed that the proprietors received salaries and extra bonuses corresponding roughly more than £ 2,000 annually between 1921 and 1923.[123] This extravagant income was supported by patients' payments. They paid not only an expensive weekly maintenance rate, but also extra daily supplies whose arbitrary profit for the institutions was about 20 percent.[124] The sale of asylum sundries was problematised by the National Society for Lunacy Reform, an anti-asylum organisation. In an internal memorandum of the Board of Control, in 1926, the Society alleged that the proprietors of Camberwell House, a private asylum in London, gained extravagant capital bonuses from 'the charges for

[123] *Report of the Royal Commission on Lunacy and Mental Disorder*, p. 133.
[124] *Ibid.*

clothing and other requisite purchases for patients or special amenities afforded to them,' and allotted them to its medical superintendent and other medical officers.[125]

Another unpublished file of the Board of Control also contributes to showing the precise economy of private asylums. In particular, it shows that provincial private asylums drew considerable profits. Estimated from Table 6-7, provincial private asylums were in the market that annually yielded 400,000 pounds for approximately 40 medical and 80 lay proprietors. The financial difference between each institution depended on whether it had good agents that could bring profitable patients in. Table 6-9 shows that the financially thriving private asylums in the provinces employed locally influential consultant physicians.

[125] MH51/826.

Table 6-7. Finance of Provincial Private Asylums, 1924 (1)

Institution	Patient No.	Total Income	Income Paid by Patients	Income per Patient per Week	Total Expenditure	Expenditure per Patient per Week	Profit	Profit per Patient per Week
Old Manor	493	£76,091	£75,817	£3.0	£48,817	£1.9	£27,128	£1.1
Ticehurst House	87	£64,477	£64,477	£14.3	£55,797	£12.3	£8,680	£1.9
Laverstock House	61	£17,602	£17,529	£5.5	£10,845	£3.4	£6,756	£2.1
Malling Place	38	£9,376	£9,376	£4.7	£3,588	£1.8	£5,787	£2.9
Heigham Hall	59	£15,882	£15,882	£5.2	£10,937	£3.6	£5,484	£1.8
Grendosill	33	£9,066	£9,031	£5.3	£5,000	£2.9	£4,066	£2.4
Haydock Lodge	146	£30,419	£30,407	£4.0	£27,136	£3.6	£3,283	£0.4
Tue Brook Villa	46	£8,624	£8,624	£3.6	£5,249	£2.2	£2,752	£1.2
Plympton	21	£6,402	£6,341	£5.8	£4,056	£3.7	£2,346	£2.1
Littleton Hall	23	£7,925	£6,766	£5.7	£5,765	£4.8	£2,159	£1.8
Brislington House	85	£34,031	£29,598	£6.7	£28,419	£6.4	£2,072	£0.5
The Retreat	50	£8,205	£7,696	£3.0	£6,254	£2.4	£1,950	£0.8
Northwoods House	33	£10,335	£10,009	£5.8	£8,508	£5.0	£1,817	£1.1
Shaftesbury House	37	£8,272	£8,272	£4.3	£6,690	£3.5	£1,582	£0.8
Bailbrook House	25	£10,622	£10,502	£8.1	£9,195	£7.1	£1,427	£1.1
The Grove	20	£6,995	£6,961	£6.7	£5,663	£5.4	£1,332	£1.3
The Grove House	35	£11,024	£11,013	£6.1	£9,867	£5.4	£1,156	£0.6
Bishopstone	10	£4,235	£4,186	£8.1	£2,900	£5.6	£1,039	£2.0
Ashwood House	25	£6,355	£6,281	£4.8	£5,391	£4.1	£964	£0.7
Kingsdown House	35	£7,444	£7,444	£4.1	£6,501	£3.6	£943	£0.5
Middleton Hall	32	£6,549	£6,529	£3.9	£5,843	£3.5	£705	£0.4
Fiddingdon House	24	£5,143	£5,128	£4.1	£4,451	£3.6	£691	£0.6
St. George's Retreat	90	£27,831	£25,099	£5.4	£27,164	£5.8	£667	£0.1
Ashbrook Hall	6	£2,496	£2,496	£8.0	£1,905	£6.1	£591	£1.9
The Moat House	6	£1,938	£1,763	£5.7	£1,466	£4.7	£472	£1.5
The Grange	17	£3,790	£3,781	£4.3	£3,326	£3.8	£464	£0.5
Stretton House	31	£2,623	£2,623	£1.6	£2,196	£1.4	£427	£0.3
Periteau	5	£1,808	£1,808	£7.0	£1,587	£6.1	£221	£0.9
Oaklands	10	£2,023	£2,018	£3.9	£1,881	£3.6	£142	£0.3
Silver Birches, Epsom	7	£3,564	£3,564	£9.8	£3,469	£9.5	£97	£0.3
Wye House	17	£5,287	£5,282	£6.0	£5,190	£5.9	£94	£0.1
Average	51.84	£13,433	£13,107	£5.6	£10,486	£4.6	£2,816	£1.1

Source: MH51/829 (National Archives, Kew).

Table 6-8. Finance of Provincial Private Asylums, 1924 (2)

Institutional Size	Sample No.	Average Income	Average Expenditure	Average Profit	Market Share (Income Based)	Market Share (Profit Based)
<20	9	£ 3,571	£ 3,043	£ 495	2.6%	1.6%
21-40	13	£ 7,780	£ 5,927	£ 1,852	5.8%	5.9%
41-60	3	£ 10,904	£ 7,480	£ 3,395	8.1%	10.8%
61-80	1	£ 17,602	£ 10,845	£ 6,756	13.0%	21.4%
81-100	3	£ 42,113	£ 37,127	£ 3,806	31.1%	12.1%
101<	2	£ 53,255	£ 37,977	£ 15,206	39.4%	48.3%

Source: MH51/829 (National Archives, Kew).

Table 6-9. A List of Consulting Physicians to Prosperous Provincial Private Asylums

Asylums	Location	Consulting Physician	Position	Sampling Year
Heigham Hall	Norwich	F. W. Burton-Fanning	Consulting Physician, Norwich	1930
		H. A. Balance	Senior Surgeon, Norfolk & Norwich Hospital	1930
Old Manor	Salisbury	Gilbert B. Kempe	Practitioner, Sheffield	1914
Haydock Lodge	Lancashire	James Barr	Physician, Liverpool Royal Infirmary	1914
		Nathan Raw	Physician, Mill Road Infirmary	1914
		W. B. Warrington	Physician, Northern Hospital, Liverpool	1914
		G. E. Mould	The Grange; Physician, Sheffield Royal Hospital	1914

Source: *Medical Directories*, 1914-1930.

Economy of Consulting Business

Because of the absence of surviving documents, the actual practices of psychiatric consultants are relatively unknown. Inasmuch as this study is concerned, it is quite rare to find personal papers relating to psychiatric consulting practices. However, a letter sent to a popular journal revealed the hidden nature of this business. It was written by Hugh Munro, the proprietor of Riverhead House, a small private asylum in Kent, and sent to the *Truth*, the late Henry Labouchere's popular but radical weekly magazine.

The letter was dealt with in *Truth*'s anti-psychiatric campaign in 1919. From the end of 1919, it reported a legal case in which a plaintiff sued psychiatrists for wrongful detention: the so-called Newington versus Holman case.[126] Its focus was upon the medical certificates given wrongly to Holman, a family member well known in the shipping business. In 1916, because of mental symptoms after pneumonia, Holman visited Maurice Craig, a famous psychiatric consultant. Craig thought that Holman's symptoms could be syphilitic, and examined him by the Wassermann test. The result was positive, as Craig was afraid. Because of this result, Holman was certified as a lunatic suffering from general paralysis of the insane, by two famous London-based consultant psychiatrists, Robert Percy Smith and J. G. Porter Phillips, both of who had been colleagues of Craig at Bethlem, and he was sent to the Moorcroft private asylum in October 1916. In August 1918, Holman escaped from Moorcroft. After getting out of the asylum, he wondered why he had not died, even though he had been detained as a syphilitic lunatic for a few years. The Wasserman test given to him seemed false. With this suspicion, Holman

[126] *Truth*, December 17, 1919, pp. 1088-1089.

sued that private asylum and the two consulting psychiatrists involved with his detention for their mistakes and damages.

In reporting this incident, *Truth* denounced private asylums for their profit making nature. In particular, it questioned whether it was desirable that any one should make a private business of lunacy. The psychiatric doctor who took this question seriously was Hugh Munro.[127] In a letter, showing an intention to surrender the license of his private asylum, he revealed a fact about private sector psychiatry 'which may crystallise the amorphous suspicion so prevalent among the public that drastic reform in the management of licensed houses is imperative.'[128] The story was about the consulting psychiatrists who made profits without the check of the Lunacy Act; Munro called such profit-making 'a secret commission exacted by many of the specialists under the thinly-veiled disguise of consultations.'[129] As for this secret commission, he explained that:

> If licensee does not pay these [consultation fees] himself or his petitioners to do so, he runs the risk of losing his clientele, if he pays them he loses his self-respect. My allegation in this respect are naturally difficult of proof, but I can assert (1) that a specialist cynically informed me two years ago that, if he sent me a patient prepared to pay more than eight guineas a week he would not be content with the usual commission on the first week's fees, but would visit such a patient quarterly, and expect to receive from me a cheque for thirteen guineas at each visit. (2) That a well known consultant, eleven days after placing a patient under my care, telephoned to know if it would be convenient for my patient to receive a professional visit from him the following Friday. After a brief and absolutely unnecessary visit, he claimed, and received, from me a cheque for ten guineas which, he said, was the sum always paid him by my predecessor under similar circumstances.[130]

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[127] Hugh Munro left little biographical information. No obituary was published for his death in medical journals and popular newspapers. His brief career paths are taken from medical directories. After obtaining B.A. and M.A. at Oxford, he became assistant medical officer of the London County Council Asylum at Claybury, and served as senior assistant medical officer of the Maudsley Hospital. After the Great War, he succeeded the licensee of Tattlebury House at Goudhurst in Kent, renamed as Riverhead House, but closed this asylum in 1919 (*Annual Report of the Board of Control*, 1919). 'The Riverhead House.' It was licensed to have only 8 patients (*Ibid*).
[128] *Truth*, December 24, 1919, pp. 1146-1147.
[129] *Ibid.*
[130] *Ibid.*

Furthermore, he remarked that 'an unscrupulous licensee would find little difficulty in retaining a wealthy patient who might otherwise be judged as fit for probation or discharge,' because the Lunacy Commissioners never seemed to make a careful inquiry into each individual patient.[131] Considering what he had observed as a private asylum proprietor, he insisted that private asylums 'should be suppressed' by new legislation.

Apart from this conclusion, an important lesson for historians is that mental consultants played a predominant role over private asylum proprietors in terms of the market relationship. Consulting psychiatrists were a source for the clientele of private asylums. Disappointed at such a nature of the asylum business, Munro gave up his private asylum business in 1919. Fading away from the scene, he witnessed a rise of psychiatric consulting businesses.

[131] *Ibid.*

3. The Post-War Voluntary Admissions

Voluntary Admissions in the 1920s

Voluntary admissions, in private asylums and registered hospitals, developed significantly after the Great War, as Table 6-10 shows. In 1930, admissions of voluntary boarders were almost equal to that of certified patients. Unlike in the pre-war period, this increase was not caused by a limited number of institutions such as the Holloway Sanatorium and Bethlem Royal Hospital. By the middle of the 1920s, most of the private sector's institutions received voluntary boarders. Behind that increase were the economic interests of psychiatrists and practitioners in certifying mental patients. As Chapter 4 has demonstrated, psychiatrists employed this admission system in order to recruit and keep high-paying patients in their private institutions. This was their traditional interest in voluntary admissions. On the other hand, a new economic interest was caused by a medico-legal incident that took place in 1924. It was brought about by W. S. Harnett, an ex-patient of a private asylum, against Charles Hubert Bond, one of the medical Commissioners of the Board of Control, and George Henry Adam, the medical proprietor of the Malling Place House in Kent.[132] The following section first explains this lawsuit which caused unprecedented panic in the psychiatric and medical professions, since this led to substantial change in voluntary admissions in the 1920s.

[132] Before becoming the proprietor of Malling Place, George Henry Adam had been house surgeon to the Millar General Hospital and a military doctor in the Red Cross. His educational and familial backgrounds are unknown (*Medical Directory*, 1930, p. 436).

Table 6-10. Admissions of Certified Patients and Voluntary Boarders in the Private Sector, 1914-1930

Year	Registered Hospitals		Metropolitan Asylums		Provincial Asylums		Certified Patients	Growth Rate	Voluntary Boarders	Growth Rate
	Certified	Boarders	Certified	Boarders	Certified	Boarders				
1914	839	239	611	63	615	120	2,065	N/A	422	N/A
1915	787	212	624	20	558	50	1,969	95.4%	282	66.8%
1916	765	228	743	23	490	58	1,998	101.5%	309	109.6%
1917	645	201	659	23	470	47	1,774	88.8%	271	87.7%
1918	700	N/A	653	34	590	66	1,943	109.5%	N/A	N/A
1919	733	278	858	34	620	75	2,211	113.8%	387	N/A
1920	719	N/A	709	28	638	73	2,066	93.4%	N/A	N/A
1921	718	330	688	121	562	194	1,968	95.3%	645	N/A
1922	650	312	655	137	490	238	1,795	91.2%	687	106.5%
1923	598	325	621	138	691	258	1,910	106.4%	721	104.9%
1924	609	436	553	169	483	296	1,645	86.1%	901	125.0%
1925	600	470	530	196	405	319	1,535	93.3%	985	109.3%
1926	577	574	443	257	423	296	1,443	94.0%	1,127	114.4%
1927	581	576	422	260	366	357	1,369	94.9%	1,193	105.9%
1928	562	668	537	312	437	445	1,536	112.2%	1,425	119.4%
1929	610	669	525	300	315	448	1,450	94.4%	1,417	99.4%
1930	462	577	506	337	477	429	1,445	99.7%	1,343	94.8%

Sources: *Annual Report of the Board of Control*, 1914-1930.

Voluntary Admission and Medical Defence

In 1912, W. S. Harnett was detained as a certified lunatic at Malling Place for several weeks, but was allowed to leave for 28 days on probation. During this leave, he went to see Bond at the office of the Board of Control to appeal for his wrongful detention at the institution. Without taking it seriously, Bond illegally detained him and contacted Adam by telephone in order to send him back. Bond's duty was,

though, to protect patients from wrongful confinement. As a result, Harnett was taken back to the Malling Place, being kept there until 1921 when he escaped.

After gaining his freedom from the asylum, Harnett contacted a psychiatrist and a neurologist not involved with his detention to confirm his sanity, and they did so. He immediately decided to sue Bond and Adam for damages caused by their wrongful detention. In the court, the jury found Harnett as sane, and ruled damages at £ 17,500 against Bond, and £ 7,500 against Adam. This caused a panic among general practitioners and consulting psychiatrists because they frequently certified patients as lunatics. In particular, they were shocked at the large amount of damages levied on Bond and Adam. The amount, in fact, exceeded extraordinarily the usual liabilities in the case of wrongful detention.[133]

Practitioners worried that they would be so vulnerable as Bond and Adam. A *Lancet* editorial stated that the Harnett case revealed 'how serious is the responsibility which is laid upon our profession in regard to the certification of lunatics.'[134] To avoid such a responsibility, some practitioners insisted that medical certificates of lunacy should be confidential documents kept by each institution for the reason of 'professional etiquette.'[135] To consider a practical measure to lessen the legal risk of the lunacy certificate, the BMA called for a conference to consider Harnett's case, inviting the President of the Royal College of Physicians of London, President of the Royal Society of Medicine, the medical members of Parliament, and representatives of the Medical Defence Union, London, the Counties Medical

[133] For example, in 1891, two certifying doctors, Alfred Carpenter and M. C. Dukes, were given a verdict of £ 2,000 for damages of wrongful confinement (*British Medical Journal*, August 15, 1891, pp. 388-389).
[134] *Lancet*, March 8, 1924, p. 503.
[135] *Ibid.*, April 12, 1924, p. 776.

Protection Society, the MPA, and the Medico-Legal Society.[136] This invitation documents how the medical profession as a whole was disturbed at the incident.

Psychiatrists were also inevitably involved with the dispute caused by the case of Harnett versus Bond and Adam. They worried about the possibility that this case would be applied to other similar cases of wrongful certification. For this reason, they insisted on the necessity of the indemnity of certifying doctors. For example, Henry Rayner argued that general practitioners should not be required to take any responsibilities for carrying out an act prescribed in the 1890 Act, since their duty was merely to give professional advice as to treatment, not to exercise statutory power.[137] Medical attention was increasingly paid to a specific matter: how to avoid the legal risk of lunacy certification. *Lancet* editorials stated that certifying doctors simply provided the material that magistrates would examine.[138]

The House of Lords reversed the previous sentence, by acknowledging that no responsibility for the detention of Harnett could be laid on Bond or Adam. This, however, did not bring an end to doctors' panic. Rather, medical practitioners had already become reluctant to certify mental patients. A *Lancet* editorial remarked that 'no medical men would ever again certify a man whom he believed to be insane, if, that is to say, in the event of his being found to have been negligent, he was to be held responsible at law for all damages that flowed therefrom.'[139]

A practical measure to the legal risk was devised by an insurance broker. In *The Lancet* on March 22, he proposed that all members of the medical profession consider protecting themselves individually by means of insurance, because the legal action of 'some ungrateful or spiteful client' would ruin doctors' professional life

[136] *British Medical Journal*, March 8, 1924, p. 437.
[137] *Lancet*, April 12, 1924, p. 776; *British Medical Journal*, May 3, 1924, p. 799.
[138] *Lancet*, May 8, 1926, p. 949.
[139] *Ibid.*, April 26, 1924, p. 871.

financially.[140] After this proposal, both *The Lancet* and *British Medical Journal* claimed the necessity of establishing adequate protection for medical practitioners through the membership of medical defence societies: the London and Counties Medical Protection Society and the Medical Defence Union. As a result, doctors rushed to the above societies for medical defence. In 1924, both organisations had an extraordinary number of recruits.[141] To prepare for the second Harnett's case, they extended the indemnity into unlimited.[142]

The medical defence was not necessarily based on exaggerated anxieties, since the Medical Defence Union reported similar legal cases brought about after Harnett's case.[143] Harnett also sued Henry Hope Fisher, a practitioner at Sittingbourne in Kent in 1926 for his wrongful certification.[144] Fisher had a verdict of £ 500 at the first stage of the court procedure, though he later won his innocence in higher courts.[145]

The doctors' anxieties about the legal risk for lunacy certification reinforced the psychiatrists' political movement for an amendment of the Lunacy Act of 1890. Referring to the case of Harnett v. Bond and Adam, *The Lancet* stated that 'whether the judgement on appeal holds good or not, makes no difference to the fact the lunacy laws must be amended. Medical men cannot face the risk under which, it seems, they lie at present, and for their protection, as well as for that of the public,

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[140] *Ibid.*, March 22, 1924, p. 623.
[141] The Medical Defence Union had 1,118 new members in 1924, although it had had 200 recruits between 1915 and 1920 (*Ibid.*, September 26, 1925; Robert Forbes, *Sixty years of medical defence*, London: Medical Defence Union, 1948, p. 90). To be a member of this society, doctors were required to pay £ 1 for annual subscription or to pay £ 25 for life membership (*The Annual Report of the Medical Defence Union*, 1924, p. 2). As for the history of the Medical Defence Union, see T. Cecil Gray, 'Reflection on a centenary and on thirty years of medical defence,' *Annual Report of the Medical Defence Union*, 1985, pp. 9-21.
[142] Robert Forbes, *op.cit.*, pp. 65-76.
[143] *The Annual Report of the Medical Defence Union*, 1924, p.17
[144] Henry Hope Fisher was educated at St. Mary's Hospital and became a police surgeon of the North Division of Portsmouth (*Medical Directory*, 1930, p. 669).
[145] *Lancet*, April 24, 1926, p. 882; *Ibid.*, May 1, 1926, p. 932.

the sooner these reforms are instituted the better.'[146] Later, this journal also stated that:

> At present the medical practitioner is being asked to certify at the risk of an unlimited personal liability in damages – a threat or penalty to which no other kind of witness is exposed. This is the point at which the lunacy law must be reformed if the country does not desire to see doctors deterred by a series of adverse verdicts from volunteering their evidence in future.[147]

The individual interest of doctors pushed forward with the politics of psychiatry.

Not only through medical journals, but at the Royal Commission on Lunacy and Mental Disorder, the medical profession disputed the issue of medical defence. In particular, the BMA sent their representatives to the Royal Commission for protect the protection against accusation of wrongful certification of lunacy. They demanded legislative indemnity for the certification. Despite the BMA's intensive demand, the Royal Commission did not allow practitioners to avoid the liability for wrongful certification, because of the legislative impossibility of allowing only the medical profession to have such a privilege under civil laws. Although accepting this result, the BMA continued to demand full indemnity.[148]

The lawsuit of Harnett versus Bond and Adam was, as Clive Unsworth has argued, a great support to psychiatrists' political attempts for amendment to the 1890 Act.[149] However, it had a more important impact upon the practice of English psychiatry; again on the issue of voluntary admissions. The doctors reluctant to certify mental patients began recommending voluntary admissions to protect themselves from wrongful detention. Ian D. Suttie (1889-1935), a Scottish psychiatrist, remarked in *The Lancet* that 'if the practitioner desires his security, he

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[146] *Ibid.*, March 8, 1924, p. 503.
[147] *Ibid.*, July 30, 1927, p. 237.
[148] *Journal of Mental Science*, October 1927, pp. 767-768.
[149] Clive Unsworth, *op.cit.*, pp. 186-187.

needs not certify,'[150] since to say 'yes or no' to the question of whether the patient was a lunatic was difficult for medical practitioners.[151] This view was confirmed by a witness at the Royal Commission, Cecil Chubb (1876-1934) who was the lay proprietor of the Old Manor private asylum in Somerset and famous for being the donor of Stonehenge.[152] He said that since the Harnett case, his institution had received many more applications from would-be voluntary boarders than ever, simply owing to the great reluctance on the part of doctors to certify. In saying so, Chubb gave his personal experience that a certifying doctor said that 'he would not certify a case for £ 20,000.'[153] By recommending that their patients be voluntary boarders rather than certified lunatics, medical practitioners alleviated their anxieties about the legal risk of wrongful confinement.

If recommending voluntary admission for their patients in avoidance of lunacy certification, general practitioners need not face any practical disadvantage. Whether they certified or not, they could receive consulting fees. Maurice Craig, for example, witnessed that he received £ 100 for one mere consulting session for a mental patient to be certified.

For reasons of medical defence, voluntary admission increased from 1924 significantly, apart from the rhetoric of early treatment of mental disorders. In 1924,

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[150] *Lancet*, March 22, 1924, p. 624. Ian Dishart Suttie was well known in London for his work at the Institute of Medical Psychology in his later life. Before working there, he had attended war services and asylum works in Scotland as junior staff at the Glasgow Royal Asylum and medical superintendent at a criminal asylum at Perth. In London, he studied Freudian psychology at the Tavistock Clinic and published several books on it (*Ibid.*, November 2, 1935).

[151] *Ibid.*, March 8, 1924, p. 503.

[152] Cecil Herbert Edward Chubb was from a gentleman's family in Wiltshire. He was educated at the Christ's College, Cambridge and called to the Bar in 1907. An auction in 1915 made him famous nationally: that of Stonehenge. He bought this premise for £ 6,600 and donated it to the nation. In Witshire, he was a magistrate and chairman of the Salisbury Gas Company (*Times*, September 24, 1934, p. 17).

[153] *Minutes of evidence taken before the Royal Commission on Lunacy and Mental Disorder*, 1926, p. 275.

voluntary admission was rediscovered as a tool of medical defence against risks to individual wealth.

Entrapping Voluntary Boarders

In the 1920s, psychiatrists also seemed to have promoted the voluntary boarder system in order to enclose prospective patients in the mental health market, as in the Holloway Sanatorium. The press reported scandals in which private mental health institutions transferred voluntary patients into certified lunatic status, evading the 1890 Act cunningly. The reason for this supposedly was institutional survival.

In June 1920, an inmate of a private asylum wrote a series of recollections of his asylum experience in the *English Review*, a successful monthly journal at the time. The patient was given an anonymous name 'Oxonian,' and his detaining institution was unidentifiable. According to him, his family members had a high standard of respectable conduct, and this strict discipline forced him, having been traumatised in wartime, to enter a private asylum. Precisely, a lady close to his family persuaded him to enjoy a rest cure as 'a few favoured individuals received as voluntary boarders,' and he decided to be admitted to a private asylum at 'M,' being as a voluntary boarder.[154] However, at the institution, he discovered the institutional machinery for certifying boarders.

One day, the Oxonian was introduced to a gentleman called 'Captain W' at the asylum. Its doctor explained that this gentlemen was a military man whom he

[154] *English Review*, June 1920, pp. 529-530.

invited at Oxonian's request to see 'someone from the outside world.'[155] Captain W was, however, indeed a RAMC doctor coming to certify the Oxonian. The Oxonian found out this fact much later when seeing the bill for a guinea for the certificate of his lunacy, which had been prepaid by the institution. In the certificate, the army doctor confirmed that the Oxonian took 'a morbid view of every thing,' but he did not fill in the blank provided for 'symptoms of insanity observed by the others.'[156] As for this imperfection, the Oxonian thought that the asylum attempted to certify him as a lunatic in order to secure incarceration of patients from respectable families, which was deliberately planned and assisted by 'two local doctors habitually employed by the asylum.'[157]

He had plenty of reasons to believe so. As done at the Holloway Sanatorium, the asylum staff seemed to have made an application for transferring him into a certified lunatic, since his relatives who should be responsible for this procedure were a hundred miles away, but it was completed within the last few days before the expiration of the period for which the Oxonian agreed to reside as a voluntary boarder. On these grounds, the Oxonian resorted to alleging that the institution entrapped him. He wrote:

> For under existing methods, whenever the sanity of the delinquent at the time of his delinquency is verifiable, the necessity arises of inducing "certifiable symptoms" after the trapping and incarceration have taken place, the victim of respectability being plunged into conditions in which emotion becomes too strong to be concealed and a state of prostration is speedily reached.[158]

This was exactly the institutional machinery which had been practiced in the Holloway Sanatorium and had been described by George Henry Savage.

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[155] *Ibid.*
[156] *Ibid.*
[157] *Ibid.*, p. 529.
[158] *Ibid.*, p. 528.

As for the Oxonian's case, the Commissioners of the Board of Control did not operate any independent inquiry, but issued a circular notice to all the private asylums and registered hospitals in 1921.[159] Based on the Oxonian's charge, they referred to the institutional means whereby voluntary boarders were certified as a lunatic without proper notice of their rights. The Board sought to improve this, reminding hospital managers about the law with regard to the rights of voluntary boarders at admissions.[160] It also demanded the managers not to certify boarders. This was the first time that the central authority of lunacy administration provided restrictions on the institutional management of voluntary admission - in particular, certification of voluntary patients. Yet, hospital managers and psychiatrists were unwilling to carry out this new rule, though they afforded no explanation.[161] This seems to show how important the institutional machinery of certifying boarders was.

Finding out about the Oxonian's experience, Sara Elizabeth White began her criticism over the private trade in lunacy, including the business of the institutional transfer of voluntary boarders into certified lunatic status. Her stage was *Englishwoman*, a leading magazine for women's liberation. From October 1920, she began a series of articles on 'Lunacy Laws.' Referring to Oxonian's experience, she insisted that his case was 'by no means an isolated instance; the present writer has come across many such. The secret certification of voluntary boarders is, in fact, almost more common than their release.'[162] From this viewpoint, she criticised the 1920 Ministry of Health (Miscellaneous Provisions) Bill whose Clause 10 was

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[159] *Annual Report of the Board of Control*, 1921, pp. 50-51.
[160] *Ibid.*
[161] *Ibid*, p. 52.
[162] *Englishwoman*, October, 1920, p. 2. White objected to the 1920 bill of the Ministry of Health, saying that 'It is, no doubt, a very convenient arrangement for the proprietors of mental homes to have patients consigned to them for detention on the sole recommendation of one doctor without ay judicial investigation or appeal. But the ordinary outlook of the public (as the said article sagely comments) has also to be reckoned with, displaying as it sometimes does "meticulous care for the liberty of the individual"' (*Journal of Mental Science*, July 1920, p. 342). She instead advocated fully public-supporting mental homes, not asylums.

aimed at extension of the voluntary boarder system to any mental experts approved by the Ministry. She argued that such extension would bring psychiatrists the 'first-fruits' of the transfer of boarders into certified lunatics. That is, she meant that the bill would enable psychiatrists to freely receive mental patients without legal checks. In the next article in November, she also referred to medical men who could have benefits from the extension of voluntary admission. They were doctors 'anxious to receive and take charge of "the incipient mental cases" for profit, who were to be hereby received any liability for infringement of Section 315 of the Lunacy Act (which section imposes a penalty for detention effected without compliance with the Act).'[163] In this light, voluntary admission was free from such anxieties, as the lawsuit of Harnett v. Bond and Adam would show in 1924. This is exactly the case that Chubb pointed out to the Royal Commission.

White's criticism of psychiatrists' mismanagement of voluntary admissions led to another criticism. It was of psychiatrists' employment of the word stigma in their emphasising the humanitarian value of early treatment of mental diseases. She remarked that:

> It has always been a habit of Lunacy people [psychiatrists] to make a bugbear of the 'stigma' of certification- i.e., of the necessary procedure of judicial investigation before committal. They maintain that stigma is due to the judicial procedure prescribed by law for the protection of the subject. They say to the patient, 'What an awful disgrace to be certified insane! We propose to detain you for your good, while dispensing with such procedure.' It is easy to see what channels for the furtherance of unrestrained detention are thus opened.[164]

Behind the psychiatrists' attack on the stigma of legal certification was, she argued, their wishes to practice privately and free from the legal restrictions.

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[163] *Englishwoman*, November 1920, p. 82.
[164] *Ibid.*, November, 1920, pp. 84-85.

She continued to unveil the rhetorical manipulation of psychiatrists. Questioning why they tended to 'dwell upon the injury entailed by certification, and on the privilege of being exempt from it,' she argued that it was to enable them 'to cast their net more widely to receive without legal check all those who were anxious to escape the dreaded stigma,' and that psychiatrists might feel 'confirmed in the comforting assurance that the longer this dread of stigma can be kept alive, the more secure they were against any legal liability, or against the risk of legal action dragging into publicity things which in their view were better hidden from the light of day.'[165]

White's criticisms were in line with those of the National Society for Lunacy Reform founded for the protection of liberty of mentally ill patients in 1920.[166] In 1922, Barbara Ayrton Gould (1886–1950), the secretary to the Society, pointed out the danger of voluntary admission in *The Times*, emphasising that voluntary boarders were easily transferred to certified lunatics in mental health institutions.[167] White and Gould's stories were grounded on the collective experiences drawn from the Society's 1000 members and 600 subscribers, who were ex-patients and their relatives and contributed £ 727 to the Society in 1925.[168] This fact cannot be overlooked, because their participation might have continuously reminded them of the very disgraceful experience of asylum detention. Thus, it seems reasonable to

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[165] *Ibid.*

[166] The National Society for Lunacy Reform had fifteen executive members: R, Montgomery Parker, Lieutenant-Colonel R. O. Boger, Lucy Buxton (1888–1960), Coleridge Farr, J. W. J. Cremlyn, D. J. Davis, B. Ayrton Gould, the Duchess of Hamilton (1878-1951), Everett Howard, Comm Lamb, C. E. Thwaites, Octavia Lewin (-1956), L. K. Schartau, A. J. Smith and Sara Elizabeth White. Among them, nationally famous figures were such female suffragettes as Ayrton Gould and Octavia Lewin. The Chairman Montgomery Parker was an unknown and non-practicing barrister (*Times*, October 16, 1950, p. 8; *Lancet*, January 7, 1956, p. 58; *Times*, December 29, 1955, p. 10).

[167] *Ibid.*, January 25, 1922, p. 11.

[168] *Annual Report of the National Society for Lunacy Reform*, London, 1926; Minutes of the Royal Commission on Lunacy and Mental Disorder, 1926, p. 420.

think that their participation could have been caused by their unbearable experiences in asylums.

Along with the story of Oxonian, there were similar cases. Dating back to 1917, a female asylum patient sued a registered hospital for wrongful detention through the machinery of certifying voluntary boarders. The registered hospital was St. Andrew's Hospital for Mental Diseases at Northampton. The heroine was Miss Lillian J. Gaul who was placed there as a voluntary boarder in April 1917, but later certified as a lunatic without having opportunities for claiming her voluntary status while a boarder.[169] She sued the hospital and its doctors for damages, but the court did not award her for the alleged wrongful certification, because the justice found her obsessed. For the same reason, her appeal was dismissed in the Court of Appeal.[170]

In Parliament, however, Robert Richardson (1862-1943), the Member of Parliament for Houghton-le-Spring in Durham, persistently raised this issue between 1921 and 1926.[171] In responding to his questions, the Commissioners of the Board of Control provided a brief inquiry. Their conclusion was the same as the one drawn from the hospital's own inquiry that there was no ground for the allegation posed by Miss Gaul.[172] Importantly, however, she was detained at that institution against her will, even while she had been an inmate on a voluntary status.

Even in the Royal Commission that recommended deregulation of voluntary admission, several ex-patients witnessed that they were transferred from voluntary

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[169] *Lancet*, July 15, 1922, p. 148.
[170] *Ibid.*, December 16, 1922, p. 1299.
[171] *Parliamentary Debates*, Vol. 146, 1921, pp. 1814-1815; *Ibid*, Vol. 157, 1922, p. 446; *Ibid*, Vol. 171, 1924, pp. 652-653; *Ibid*, Vol. 171, 1924, pp. 2631-2632; *Ibid*, Vol. 175, 1924, pp. 630-631; *Ibid*, Vol. 176, 1924, p. 902; *Ibid*, Vol. 198, 1926, pp. 2299-2300.
[172] *Annual Report of the Board of Control*, 1922, p. 28.

boarders to certified lunatics against their will.[173] Referring to her own experiences, the ex-patient Miss G. remarked 'I was trapped; I knew in the first few hours that I was trapped; and the sense of trapping quite obscures any other misery, anything that can be called misery.'[174] Surprisingly, the technique to certify her was the same as that was applied to the Oxonian. She was told by asylum doctors, 'Now, Miss G. you have asked to see somebody from the outside world. I have brought you Captain W.'[175] The mental hospital and doctors that were in charge of her were not shown in the Commission's report, but her witness indicated that there were such specific institutional techniques to certify voluntary boarders.[176] The reason for her certification seems that she was a good client who paid more than 4 guineas a week.

The non-medical knowledge of voluntary admission was much related to its abuses. The *Justice of the Peace*, in reporting the Royal Commission on Lunacy and Mental Disorder, expressed that 'lawyers may find grave difficulty in framing any legislation which will be found to work satisfactorily if the voluntary patient system is extended so as to apply to the admission of persons who are certifiably of unsound mind.'[177] Referring to the possible abuse of voluntary admission, it also stated that 'it might be dangerous otherwise further to extend the existing facilities for the admission of a voluntary patient who is certifiably insane.'[178]

In politics, too, voluntary admission was not necessarily exclusively an idea of early treatment. In 1930, Josiah Clement Wedgwood cast doubts upon the certification of boarders in the discussion of the 1929 bill. He was much aware of the machinery of asylum businesses in which patients admitted into asylums

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[173] *Minutes of the Royal Commission on Lunacy and Mental Disorder*, 1926, pp. 882-889.
[174] *Ibid.*, p. 886.
[175] *Ibid.*, p. 887.
[176] According to her witness, the institution would be a registered hospital.
[177] *Justice of the Peace*, December 20, 1924, p. 761.
[178] *Ibid.*, p. 762.

voluntarily were often transferred into certified status, and in such a case the doctors and managers in charge of the treatment would make applications for the lunacy certification by themselves.[179] Like Wedgwood, William John Brown (1894-1960), a Labour MP for Wolverhampton West, quoted a case in which a young and female voluntary patient admitted to a private asylum was, in fact, wrongly diagnosed as having dementia praecox by a Harley Street mental consultant.[180] She was about to be certified by the institution's staff, but her relatives refused it. Later, she was found at her home as sane.

Considering these cases that indicate the institutional machinery of certifying voluntary patients, this thesis insists that by exploiting voluntary admission, private mental health institutions attempted to extend market presence. From the statistical viewpoint, the increasing voluntary admissions enriched private institutions. As Table 6-10 shows private asylums improved their bed occupancy from 82.7 percent to 96.8 percent between 1914 and 1930, by including increasing numbers of voluntary boarders. This 10 percent increase would be more significant than we expect, because these institutions would intend not only to fill the beds, but also to attract high-paying patients, because the upper and middle classes disliked legal certification more than the lower classes. Hence, the 10 percent recovery in the bed occupancy would include the patient layer of high-paying clients. With such practical value, voluntary admission became a major admission system that assisted psychiatrists' private businesses.[181]

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[179] *Lancet*, 13 May, 1930, p. 1730.
[180] *Ibid.*, pp. 1733-1734.
[181] The Report of the Royal Commission published in 1926 referred to a fact that as private asylums had increasing demands from patients in the interwar period, they raised their weekly maintenance rates (*Report of the Royal Commission on Lunacy and Mental Disorder*, p. 134).

Table 6-11. The Bed Vacancies of Private Asylums in England and Wales, 1914-1930

	Total Inmates	Metropolitan Asylums	Provincial Asylums	Certified Patients	Voluntary Boarders	Bed Vacancies Based on Certified Patients	%	Bed Vacancies Based on Voluntary Boarders	%
1914	3,366	1,624	1,742	2,713	72	653	80.6%	581	82.7%
1915	3,386	1,644	1,742	2,745	70	641	81.1%	571	83.1%
1916	3,386	1,644	1,742	2,742	81	644	81.0%	563	83.4%
1917	3,386	1,644	1,742	2,791	70	595	82.4%	525	84.5%
1918	3,342	1,644	1,698	2,699	N/A	643	80.8%	N/A	N/A
1919	3,106	1,424	1,682	2,734	100	372	88.0%	272	91.2%
1920	3,093	1,416	1,677	2,703	N/A	390	87.4%	N/A	N/A
1921	3,033	1,416	1,617	2,620	N/A	413	86.4%	N/A	N/A
1922	3,033	1,416	1,617	2,603	127	430	85.8%	303	90.0%
1923	3,027	1,416	1,611	2,606	148	421	86.1%	273	91.0%
1924	3,027	1,416	1,611	2,797	139	230	92.4%	91	97.0%
1925	3,027	1,416	1,611	2,739	208	288	90.5%	80	97.4%
1926	3,008	1,411	1,597	2,685	245	323	89.3%	78	97.4%
1927	3,008	1,411	1,597	2,637	263	371	87.7%	108	96.4%
1928	3,008	1,411	1,597	2,536	308	472	84.3%	164	94.5%
1929	3,008	1,411	1,597	2,572	339	436	85.5%	97	96.8%
1930	3,008	1,411	1,597	2,559	354	449	85.1%	95	96.8%

Sources: *Annual Report of the Board of Control*, 1914-1930.

Voluntarily admitted patients were in a vulnerable position in which they could be transferred to long-term inmates of the private mental health institution. In Sara Elizabeth's words, they could be captured in 'a widened net of voluntary admission' provided by the psychiatric profession. This net benefits the profession as well as patients.

4. Psychiatrist's Strategies for the Inter-Professional Competition

As Chapter 5 has argued, the market competition of psychiatry became intense after the Great War caused the mass participation of non-psychiatric doctors. There were neurologists who began practices connected with the treatment of shell-shocked soldiers, subsidised by the Ministry of Pensions. In the light of this competition, mental consultants sought wealthy patients, connecting to London general hospitals, private asylums, and neurological hospitals. Registered hospitals such as the Holloway Sanatorium in Surrey, the Royal Cheadle Lunatic Asylum at Manchester, and St. Andrew's Hospital at Northampton, also competed with the professional newcomers, by accumulating chronic but high-paying patients. During the same period, nursing homes run either by practitioners or layperson received mental cases illegally. The 1920s was such a period as many agencies of psychiatry and medicine and lay interested groups competed with each other in order to establish a new jurisdictional settlement around the treatment of mental diseases.

Attacking and Defending Private Asylums

The intensive competition in the psychiatric market, which had been promoted since the late nineteenth century,[182] was accelerated by the 1890 legislation. Its restriction on private asylums brought about a monopoly of the private asylum business. To bring an end to it and make room for themselves, psychiatrists criticised the vested interests of the existing proprietors. In 1925, Reginald Langdon Langdon-Down, an

[182] Janet Oppenheim, *op.cit.*, pp. 31-34.

eminent mental consultant and the proprietor of a certified institution for mental defectives, raised this issue in the Royal Commission on Lunacy and Mental Disorder on behalf of the BMA.[183] He identified a problem in the 1890 Act with a monopoly of the private asylum business granted only to a certain number of doctors, and emphasized that patients and their friends wished to remove the monopoly for themselves.[184] The other BMA representative, Sir Jenner Verrall (1883-1951), a consulting surgeon famous for his representation of general practitioners, also told the commission that 'we believe there is a demand from the public for these places [private asylums].'[185] To open up the private asylum business was a crucial agenda for the psychiatric profession.

From the Great War to the early 1920s, however, one psychiatrist actively defended the private asylum business: Lionel Alexander Weatherly, a mental consultant in Bournemouth and the late proprietor of the Bailbrook House private asylum at Bath. He argued that private asylums and single care of mental cases that provided therapeutic possibilities far greater than in other large institutions were deprived of patients.[186] In doing so, he defended private asylums.

In regard to public asylums, he argued that they made an inroad to the private patient market, by providing cheaper accommodation for private patients at a charge

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[183] Reginald Langdon Langdon-Down was the son of an alienist J. L. H. Langdon-Down known for 'Langdon-Down's disease.' Reginald was educated at Trinity College, Cambridge and studied medicine at the London Hospital. After having M.R.C.P. in 1894, he settled his private practice at Teddington, and later took over the proprietorship of Normansfield, a home for mental defectives run by his family. In medical politics, he was drawn into the inner counsels of the BMA and served its Central Ethical Committee (*Lancet*, June 18, 1955, pp. 1279-1280).

[184] *Minutes of evidence taken before the Royal Commission on Lunacy and Mental Disorder*, 1926, p. 582.

[185] *Ibid.*, p. 583. As for Paul Jenner Verrall, see *Lancet*, May 5, 1951, p. 1022.

[186] *Ibid.*, February 14, 1914, p. 497. He had believed therapeutic advantages of private asylums since his first book published in 1882 (Lionel Alexander Weatherly, *The care and treatment of the insane in private dwellings*, London: Griffith and Farran, 1882, pp. 29-51). Also see Peter McCandless, *op.cit.* 1983, pp. 96-97.

of less than £ 2 per week.[187] Indeed, public asylums extended their net over the middle-class clients whom private asylums had originally targeted. This is seen in medical advertisements. In 1890, no public asylum posted advertisements in the medical directories, but by 1914, the City of Canterbury Mental Hospital, Chester County Asylum, City of London Mental Hospital, East Sussex County Asylum, and Cheshire County Asylum, began advertising their private patient accommodation. So did the London County Council, City of Portsmouth Mental Hospital, Derby Mental Hospital and Bucks Mental Hospital by 1930.

In the statistics issued by the Lunacy Commissioners and Board of Control, too, public asylums increased their private patients from 936 in 1890 to 9,499 in 1930.[188] This 1,014 percent increase in forty years was a significant change in the market of mental health, since the growth rate in the total patient number in this period was only 142 percent. This was caused by the expansion of public asylums and the 1890 Act's restrictions on private asylums. The latter specially made public asylums possible to be responsible for the market for private patients. This commercialisation of public asylums were observed by Lionel Weatherly and Robert Armstrong-Jones. In 1903, he witnessed the growth that under the 1890 Act, several counties, cities and boroughs provided inexpensive accommodations for the patients at the charge of between £ 1 to £ 2 per week.[189]

Weatherly's other enemy was registered hospitals. They gained a vast amount of earnings from wealthy paying patients, in spite of their statutory duty of

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[187] *Lancet*, August 5, 1916, p. 248. London County Council's advertisement for private patients stated that its rate was 1 pound 4 shillings and 11 pence per week for those residing in the County of London; for others 1 pound 8 shillings and 5 pence; The City of London provided similar accommodation at 2 guineas; The City of Portsmouth charged 2 and half guineas to its private patients (*Medical Directory*, 1930, pp. 2220-2223). The City of Canterbury and Bucks Mental Hospital also posted advertisements but its rate is not shown.

[188] *Annual Report of the Commissioners in Lunacy*, 1890-1909; *Annual Report of the Board of Control*, 1914-1930.

[189] *Lancet*, December 26, 1903, p. 1778. The actual conditions of public asylums' management of private accommodations have been rarely explored.

providing charitable care, Weatherly said. From the late nineteenth century, in fact, they had changed their nature from charitable to profit-seeking. While decreasing their charitable admissions, they concentrated on high-paying patients, as shown in Table 6-12. This was because of fewer subscriptions and bequests raised to these institutions, except the Bethlem Royal Hospital. Their finances did not 'admit any considerable extension of their charity.' [190]

This trend became manifest in the early twentieth century. In 1906, the Lunacy Commissioners reported that 'the number of patients maintained gratuitously is exceedingly small, and in many the number of those received at low rates is not proportionate to the gross income of the hospitals concerned.'[191] In 1929, the Board of Control reiterated this view, stating that the endowments of the registered hospitals were so small that 'there is a natural temptation to seek to attract profitable patients in order to balance the budget.'[192] For private asylum doctors, both public asylums and registered hospitals unjustifiably deprived private asylums of their high-paying and modest-paying patients. In doing so, the former institution spent the public capital, the latter abandoned their charitable mission.

Table 6-12. Charitable and Uncharitable Admissions in Registered Hospitals, 1882-1928

Bethlem Royal Hospital	1868	1882	1904	1928
Charitable Cases	N/A	100.0%	80.0%	34.0%
Cases charged more than 42s per week	-	-	-	27.0%
Other Registered Hospitals	**1868**	**1881**	**1904**	**1928**
Charitable Cases		5.0%	3.1%	1.3%
Cases charged more than 30s per week	22.0%	-	-	-
Cases charged more than 30s 6d. per week	-	-	62.1%	-
Cases charged more than 42s per week	-	-	-	84.1%

Source: MH51/350 (National Archives, Kew).

[190] *Annual Report of Commissioners in Lunacy*, 1891, p. 68.
[191] *Ibid.*, 1906, p. 52.
[192] *Annual Report of the Board of Control*, 1929, pp. 10-11.

Weatherly also attacked neurologists. In his *A plea for the insane*, he emphasised that mental health provisions should be operated by 'experienced physicians' who could provide 'skilled supervision and treatment.'[193] They were psychiatrists. On this basis, he criticised neurologists for their dealing with 'incipient and even more advanced cases of mental disorders by placing them in homes in which they had some definite or indefinite interest.'[194] In developing his attack on neurologists, Weatherly described neurologists' treatment as negligent. They forced patients to be 'isolated, kept in bed, fed up, massaged' and saw them 'three times a week and gave him intra-muscular injections' at a big weekly payment.[195] Despite the high-payment, most of the patients got worse than ever. This was, Weatherly insisted, the consequence of non-psychiatric treatment.

Weatherly, however, did not entirely dismiss neurologists from the psychiatric market. Rather, he suggested cooperation between them and psychiatrists, saying that 'the neurologist can give many useful hints to the psychologist is perfectly true, while the long experience of mental disease in all its aspects of the psychologist makes him still more helpful to the neurologist, and thus if these two branches of the profession work hand in hand much good will be, I feel sure, the result.'[196] His complaint was that this hand-in-hand work was not carried out, as it should have been.

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[193] *Lancet,* July 26, 1919, p. 174.
[194] Lionel Alexander Weatherly, *A plea for the insane: the case for reform in the care and treatment of mental disease*, London: Grant Richards, 1918, p. 127.
[195] *Ibid.*, pp. 129-131.
[196] *Ibid.*, p. 129.

Psychiatric Consultants and General Hospital Psychiatry

Although Weatherly defended private asylums intensively, they were no longer leading providers in the psychiatric market in the 1920s. Rather, the key to understanding the market competition in this period lays with the psychiatric consultants whose strategy was to develop private practices connected with existing private asylums, general hospitals and neurological hospitals. The consultants created individual nets to secure their own private business. Among the above connections, general hospitals were important sites for psychiatric consultants.

In the 1920s, St. Luke's Hospital for Mental Diseases began providing a psychiatric department at the Middlesex Hospital. The psychiatric consultant in charge of this project was Richard Withers Gilmour who had been the senior assistant medical officer of St. Luke's.[197] The St. Luke's hospital was a famous charitable institution presided over by George Godolphin Osbourne (1863-1927), Duke of Leeds, and thereafter run mainly by legal professionals.[198] In 1916, however, it was closed because of the financial burden caused by the wartime inflation.[199] However, in the 1920s, the governors of the hospital sought a new site and services to be provided instead. The principle of the new provision was preventive treatment for early nervous and borderland cases.[200] To accomplish this, the St. Luke's hospital governors pursued connections with general hospitals. In 1921, they agreed to the 'co-operation with the Governors of the Middlesex Hospital

[197] Richard Withers Gilmour was educated at the Durham University and St. Bartholomew's Hospital, and later became assistant medical officer of the Wadsley Asylum at Sheffield and St. Luke' Hospital (*Medical Directory*, 1930, p. 125). His familial backgrounds are unknown.
[198] H64/A/09/006 (London Metropolitan Archives). On 9 May 1922, Bond encouraged St. Luke's governors, saying that 'today it was essential for every mental hospital to make adequate provision for the early treatment of psycho-neurological cases as outpatients (*Ibid*).'
[199] H64/A/01/007; H64/A/09/006. The debt of St. Luke's hospital exceeded its income by nearly £ 800 (*Ibid*).
[200] H64/A/01/007.

for jointly establishing an outpatient department for the treatment of these cases with two small wards for the reception of inpatients.'[201] The outpatient clinic was opened in November 1922, and the two wards and six beds were attached additionally on 12 June 1923. The governors of St. Luke's Hospital commented that this joint provision was 'a new development in psychological medicine' in which patients were no longer stigmatised 'as unfortunately existed when patients applied direct to a mental institution.'[202] This project, so far, seemed fit for early treatment of mental disorder.

Apart from this evaluation of St. Luke's authorities, however, psychiatric doctors and the Middlesex Hospital had their own expectations for the joint programme. For the Middlesex Hospital, it was not their own, because most of the expenses were paid by St. Luke's Hospital. When the outpatient department was opened, the managers of the Middlesex Hospital made a statement that 'this is, we believe, the first instance of a working alliance between a general and a special hospital on such lines, and it is anticipated with confidence that the result will prove to be wholly beneficial.'[203] Afterwards, however, it did not make any reference to the project.[204]

For psychiatrists, the St. Luke's project had a different implication. Importantly, the original idea of the project arose not from the St. Luke's governors but from a psychiatrist, Charles Hubert Bond who was the most sympathetic medical commissioner of the Board of Control. He was also one of the executives of the

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[201] *Ibid.* In operating the outpatient clinic, St. Luke's Hospital made advanced payments of £ 2,000 to the Middlesex Hospital (H64/A/09/006). Gilmour was paid £ 400 annually in 1922 and it was promoted to 600 pound in 1924 at his own request (H64/A/03/013).
[202] H64/A/01/007.
[203] SC/PPS/093/39.
[204] Minutes of the Medical Committee, September 21, 1922, Middlesex Hospital Records (University College Hospital Archives).

MPA.[205] It was he who proposed the St. Luke's psychiatric outpatient clinics.[206] Under his auspices, the psychiatrist Richard W. Gilmour became the physician to the outpatient clinic. Attending the outpatient clinic, Gilmour resorted to private practices at Harley Street.[207] This combination was a great advantage for his private practice because when finding severe cases of mental diseases at the clinic that the Middlesex could not receive, he could bring them to his own private office to earn consulting fees.

According to Gilmour's report to the St. Luke's governors published in 1923, he had the following cases in his outpatient sessions: hysteria, neurasthenia, emotion neurosis, compassion and obsession, stammering, mental and functional nervous symptoms associated with physical disability, epilepsy, dementia praecox, paranoia, general paralysis of the insane, congenital mental deficiency, acute and chronic psychoses.[208] Certainly, many of these diagnoses could not be seen as uncertifiable at the time.

This peculiar feature of general hospital psychiatry was also found at St. Thomas's Hospital whose physician for mental diseases was Robert Percy Smith. In 1923, Percy Smith stated that his outpatients included general paralytics, alcoholics, epileptics and defective children. Even in saying so, he emphasised that 'many were mild cases, which were guided though by psychotherapy to recovery.'[209] This is rather strange, since the diseases that he referred to were generally thought of as chronic and hereditary. Nevertheless, he did not refer to the prognosis of such severe cases that should be sent to asylums under the Lunacy Laws. Hence, general hospital's psychiatrists did not conduct early treatment of mental diseases. Rather,

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[205] H64/A/03/013.
[206] *Annual Report of the Board of Control*, 1924, p. 51.
[207] *Medical Directory*, 1930, p. 125.
[208] H64/A/03/013.
[209] *Journal of Mental Science*, January 1923, p.551.

they found a new ground for developing their psychiatric jurisdiction, by connecting themselves with general hospitals.[210]

To defend their consulting business, psychiatrists attempted to exclude their rivals. As Weatherly did, they criticised registered hospitals for the fact that they increasingly recruited wealthier clients. In 1916, Percy Smith remarked that six major registered hospitals in England and Wales earned £ 286,000 from patients in that year, and argued that it was unsound that such charitable institutions catered 'to the wealthy and well-to-do classes rather than to the poorer members of the same social standing.'[211] The remark shows that in the 1920s, private asylums, registered hospitals and consulting psychiatrists contested for wealthy clients.

Psychiatric Consultants and Neurological Hospitals

In the 1920s, psychiatric consultants also attempted to obtain connections with neurological hospitals. This is exemplified through the case of Maurice Craig, one of the most celebrated mental consultants around Harley Street in the early twentieth century, and one of the most active psychiatrists in promoting early treatment of mental diseases through general hospital psychiatry.[212] He was also known for his political influence, because he was the chairman of the National Council for Mental Hygiene that influenced the final report of the Royal Commission on Lunacy and Mental Disorder published in 1926. After having served as the senior physician at

[210] Other psychiatric doctors and institutions also established outpatient departments to general hospitals: namely, Bethlem Royal Hospital's (Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker, and Keir Waddington, *op.cit*), Harper-Smith's at Brighton (James Gardner, *Sweet bells jangled out of tune: a history of the Sussex Lunatic Asylum (St Francis Hospital) Haywards Heath*, Brighton, 1999).
[211] *Lancet*, July 29, 1916, pp. 196-197.
[212] G. H. Brown (ed.), *op.cit.*, pp. 474-475.

the Bethlem Royal Hospital, Craig began his private practice at Welbeck Street in London. To ease his practice, he obtained a hospital position at Guy's Hospital. Succeeding George Savage, he served as the physician for mental diseases at the hospital from 1903 to 1926. Similar to St. Thomas's, this position was in fact honourary but allowed him to see patients in consultation.[213] But by the early 1920s, Guy's hospital opened a psychiatric outpatient facility at the personal request of Craig. Craig was interested not only in general hospitals, but also in private asylums, neurological hospitals, and therapeutic homes of the Ministry of Pensions. As for private asylums, he acted as the visiting physician to the Moorcroft private asylum in London. As shown in Holman's case, he earned extraordinary consulting fees in prescribing asylum treatment for his patients. From Holman, he received £ 100 a consulting session. In addition to this, he could earn visiting consulting fees, by periodically seeing patients at Moorcroft.

Craig's consulting business extended to a neurological hospital. He was the consulting physician, member of the general committee, financial committee and house committee at the Cassel Hospital for Functional Nervous Diseases located at Richmond. This hospital was established in 1919, after a donation of £ 225,000 by Ernest Cassel (1852-1921), a successful merchant banker and financier.[214] He intended to provide accommodation for 60 patients from the educated middle classes, who suffered from 'neurasthenia, nervous breakdown, loss of [physical] power not associated with evident structural changes.'[215]

The Cassel hospital was designed for early treatment of mental disorder. Its fifth annual report emphasized its advantage that patients could come there without fear against the certification of lunacy at the earlier stages of the disease, and

[213] H09/GY/A3/11/1.
[214] As for Cassel's biography, see *Times*, September 23, 1921, p. 5.
[215] *Ibid.*

consequently they would be cured easily.[216] In addition, Ernest Cassel expected the institution to bridge a niche in provisions for mild mental diseases.[217] In fact, the other institutions for the middle class were insufficient. The outpatient departments of general hospitals and the Royal Bethlem Hospital were usually very crowded, and the Maudsley Hospital, a newly established institution for the mild cases of mental diseases, was always full.

The Cassel Hospital introduced onto its managerial board many eminent consulting physicians specialising in neurology and psychiatry. The director was Thomas Arthur Ross (1875-1941) who preferred psychotherapeutics but avoided any kind of psychoanalytic methods.[218] The hospital also invited three neurologists, two general physicians and two psychiatrists: Farquhar Buzzard (1871-1945), Henry Head (1861-1940), Arthur Frederick Hurst (1879-1944), Frederick Treves (1853-1923), Lord Dawson of Penn (1864-1945), Bernard Hart and Maurice Craig. All of them were successful London consultants.

The participation of these doctors was related to their consulting businesses. To be precise, the Cassel Hospital functioned as a place of 'hospital abuse.'[219] Not only did the hospital host severe mental cases similar to other general hospitals,[220] but it also allowed its director and consulting physicians to provide consultancy for its inmates.

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[216] *Annual Report of the Cassel Hospital for Functional Nervous Diseases*, 1926.
[217] *Times*, May 7, 1930, p. 17.
[218] Thomas Arthur Ross was from a non-medical and middle-class family in Edinburgh. He was educated at the Edinburgh Academy and Edinburgh University. After having qualified and experienced several junior appointments, he had an interest in neurosis and psychotherapeutics. In the Great War, he had opportunities to learn these in the Springfield War Mental Hospital. This drove him into neurological practices in the 1920s at the Cassel Hospital (Richard R. Trail (ed.), *Lives of the fellows of the Royal College of Physicians of London continued to 1965*, London: Royal College of Physicians, 1968, pp. 359-360).
[219] The 'hospital abuse' was misconducts that medical doctors, by using their hospital appointments, took hospital patients to premises of their private practices. Also see pp. 85-86 in Chapter 3.
[220] In 1922, 47 of 185 patients at the Cassell hospital were 'psychosis,' which could not be seen as early and mild mental diseases (22.29 (Cassel Hospital Papers: Planned Environment Therapy Trust Archive)).

'Hospital abuse' was recorded in the minutes of the medical committee. In June 1921, Craig, Buzzard, Head and Ross argued about consulting works at the hospital.[221] The argument was indeed about who should be in charge of this work. In the committee, they could not find an answer, because the director resisted consulting doctors' monopoly. Hence, they asked the General and House Committee to give its opinion. Its answer was that except for administratively conducted consultancies, consulting doctors could provide consultations for inpatients who wished to have a therapeutic consulting session, and charge ten guineas a session.[222] Consulting psychiatrists and neurologists succeeded in extending their consulting business into this new hospital.

However, the director of the hospital, Ross, was dissatisfied with this decision. In December 1922, the members of the Medical Committee, Craig, Head, Hurst, and Ross, produced a new agreement that, while not being encouraged to provide consultations to former patients, the medical director should be empowered to provide his consultation for patients who wished to have it. The Committee also regulated that only when a patient's family doctor was willing, the director could at his discretion see and charge them a fee of up to 2 pounds and 2 shillings a session.[223] The Medical Director's personal charge was to be paid into 'the Medical Director's Special Fund.' In short, the agreement was that while the director defended his interest in the hospital's inmates and gained additional earnings that could be about hundred pounds a year, consulting doctors instead secured their right to have consulting sessions with ex-patients.[224]

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[221] Medical Committee Minutes, 22 June 1922 (Cassel Hospital Papers).
[222] General and House Committee Minutes, 6 July, 1921 (Cassel Hospital Papers).
[223] Medical Committee Minutes, 14 December 1922 (Cassel Hospital Papers).
[224] This agreement was approved in the General and House Committee (General and House Committee Minutes, 19 December, 1921 (Cassel Hospital Papers)).

Not only by this agreement, but by others, Cassel's consulting doctors seemed strongly interested in hospital patients. In January 1929, the Medical Committee's members considered letters describing the procedure of the Maudsley Hospital and of the Bethlem Hospital with a view to the prevention of hospital abuse. As a result of some argument, they decided 'to leave the matter in the charge of the Medical Director,' but the Director did not make any progress with this issue. At the Cassel, consulting doctors connived at hospital abuse.

The doctor who was the most active in the Medical Committee was Maurice Craig. His attendance in the Committee was far more frequent than that of the other consulting doctors. He attended 9 meetings in 1929, while the other doctors attended only 2 times on average.[225] Significantly, he was committed to all the above decisions related to consultancy in relation to the inpatients and ex-patients of the hospital.

Why did the hospital governors allow its consulting doctors and director to conduct such hospital abuse? It is unknown, but it seems that they expected consulting doctors to be agents to bring high-paying patients to the institution. For the purpose of institutional survival, as at the Holloway Sanatorium, the Cassel Hospital depended on wealthier clients. For instance, in 1921, the hospital asked Maurice Craig to submit the names of such wealthier patients that he knew.[226] In July 1921, Ross, the director, reported to the General and House Committee that 'difficulties have been found in filling the bedrooms in which there were two of four beds (one four bedded room, and five two-bedded rooms).' Receiving this report, the medical committee members agreed that 'if patients could be found to pay a higher fee,...they should be given these larger rooms for occupation as a single

[225] Medical Committee Minutes, 15 January, 1929 (Cassel Hospital Papers).
[226] *Ibid.*, 6 July, 1921, (Cassel Hospital Papers).

room.' In return for the right to provide consultancy, consulting doctors contributed to the financial survival of the hospital.

As a result of this financial directive, in 1933, the average maintenance fees paid by patients reached 5 pounds, 8 shillings and 9 pence.[227] This was rather expensive for a middle class institution. Thus, it can be said that this voluntary hospital was 'a pay-hospital for nervous invalids' constructed through the reciprocal relationship between consulting doctors who were concerned about their own individual interests, and hospital governors who were tasked to continue the institution.

It was not only Maurice Craig who established consulting practices by approaching neurological hospitals. Three other psychiatric doctors were involved with London-based neurological hospitals in the first quarter of the twentieth century. At the West End Hospital for Nervous Diseases, Thomas Outterson Wood and Fletcher Beach were appointed as physicians. Wood was a psychiatrist who had served as assistant medical officer and medical superintendent of private and public asylums.[228] After the public asylum service at the Isle of Man asylum, he came to London and established his consulting career in connection with the West End Hospital. Fletcher Beach (1845-1929) started his career at the Bethlem Royal Hospital as resident medical officer, and later became medical superintendent of the Metropolitan Asylum Board's School for Imbecile Children in Kent.[229] From 1925, the Maida Vale Hospital for Nervous Diseases appointed Edward Mapother (1881-1940), the director of the Maudsley Hospital, as consulting psychiatrist. Based upon this connection, Mapother provided extensive consulting business apart from his well-known work at Maudsley. In the early twentieth century, then, in general,

[227] 22.29 (Cassel Hospital Papers).
[228] *Lancet*, August 2, 1930, p. 270.
[229] G.H. Brown (ed.), *op.cit.*, pp. 340-341.

consulting psychiatrists expanded their consulting market into neurological hospitals.[230]

Psychiatric Consultants and the Military Sector of Psychiatry

Psychiatric consultants found financial interests in the treatment of mentally ill soldiers, which was controlled by the government. The Ministry of Pensions opened a number of neurological treatment units around the country. They consisted of 12 neurological hospitals for 1,997 patients and 41 neurological clinics for 1600 pensioners in 1925.[231] In 1926, the above hospitals and units spent £ 736,000 a year.[232]

Table 6-13. Mental Health Provisions of the Ministry of Pensions, 1921-1926

	Borderline	Neurasthenic	Defective	Total
1921-22	400	2431		2831
1922	400	1812		2212
1923	400	1194	400	1994
1924	400	749	650	1799
1925	400	386	1230	2016
1926	286	273	1214	1773

Sources: PIN15/2502.

This was, on the one hand, advantageous for psychiatrists, because some of them could operate private practices with such appointments of the Ministry of

[230] Other doctors in charge of the hospitals were physicians specialising in neurology and having other major appointments at general hospitals: for instance, George Ogilvie (1852-1919), Leonard Guthrie (?-1919), E.G. Fearnsides (1883-1919), Wilfred John Harris (1870-1960), and H. Campbell Thomson (1870-1940) at Maida Vale. All were senior London-based physicians being Fellows of Royal College of Physicians, London and staffs of London teaching hospitals. At the West End Hospital, there were William H. Broadbent, T.D. Savill (1857-1910), Frederick S. Palmer (?-1926), Eric D. Macnamara (?-1934), Frederick Golla (1878-1968), Purves Stewart (1870-1949), H. Ridley Prentice (1880-1926) Hildred Carlill (1882-1942) and Walter Rupert Reynell (1885-1948).
[231] PIN15/2500 (National Archives, Kew).
[232] PIN15/2502.

Pension's institutions. Roy Neville Craig, the late assistant medical superintendent of the Coppice Hospital for Mental Diseases at Nottingham, began his private practice with a consulting position provided by the Ministry of Pensions in the 1920s.[233] Norman Henry Oliver also opened his private practice at Lechmere, connected with the Ministry of Pensions' clinics for nervous disorders.[234] Prior to the war, both doctors had been junior psychiatrists of lunatic asylums, but could have private practices with the assistance of the Ministry of Pensions after the war.

There were reciprocal interests between such war-related institutions and psychiatrists. The hospitals needed specialists in order to run themselves, psychiatrists gaining individual material interests. This came to light when a philanthropist started special accommodation for shell-shocked soldiers in the 1920s. This was Frederick Milner (1849-1931), an eminent politician and philanthropist.[235] From 1922 to 1924, he called public attention to the fact that 6,000 shell-shocked soldiers were detained in lunatic asylums, and 30,000 nervous cases were still suffering without medical treatment.[236] He asked the public to subscribe to a philanthropic plan of the Ex-Services Welfare Society, a voluntary association that he had established, to provide non-asylum accommodation for shell-shocked soldiers. Receiving subscriptions of more than £ 30,000, the Society established the recuperative hostels located at Hampstead and at the Enham Village Centre in Kent.

To enhance the reputation of these hostels, Milner emphasised that asylums were much worse than his institutions in terms of food, medical surgery and the

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[233] *Medical Directory*, 1930, p. 591.
[234] *Ibid.*, p. 966.
[235] Frederick Milner was born in a politician family in Yorkshire. After having served as Member of Parliament for sixteen years between 1890 and 1906, he retired from national politics because of his increasing deafness. His highest appointment was the Privy Councillor in 1904. After retirement, he devoted himself to charitable activities mainly of assisting disabled soldiers in such wars as the Boer War and Great War, thereby establishing the Ex-Services Welfare Society (*Times*, June 9, 1931, p. 16).
[236] *Times*, March 7, 1922, p. 9; *Ibid.*, September 23, 1922; p. 5; *Ibid.*, October 23, 1924; p. 11; PIN15/2499.

dispensary.[237] He also referred, in the brochure of the hostels, to the disadvantage of public asylums, by extracting the letter of a 'well-known and eminent mental specialist.' This psychiatrist said that 'in regard to the cost of provisions for patients, which at one asylum was less than 6d. [pence] a day, I maintain that it is impossible to sustain a sick person adequately on this sum.'[238] Using this quote, Milner stressed that his hostels were private and charitable establishments for the shell-shocked, and differed from asylums that could not provide curative, voluntary and individual treatment.

Milner's philanthropic home for shell-shocked soldiers is well known in the history of psychiatry, but it has been overlooked that Milner's project met with elite consulting psychiatrists' interference.[239] They regarded Milner's attempt as a nuisance to their practices, because of his smearing of psychiatric services. Hence, they practically stopped supplying specialist resources to his hostels. This began with a request of the Society to George M. Robertson, an eminent Scottish psychiatrist, for finding a suitable matron for the Sir Frederick Milner's Home for the shell-shocked at Beckenham in Kent. This was because the Society had failed to employ suitable matrons and medical attendants in its first hostel in Putney Hill in 1920.[240] As a result, the Society was forced to stop its provisions. In the 1924 project, it was felt necessary to have a psychiatrist in assistance. In response to the Society, however, Robertson refused to have 'anything further to do with this matter,' because he was angry about the Society's brochure that stated that 'shell shock victims are prisoners in a pauper madhouse.' This brochure also stated:

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[237] *Ibid.*
[238] *Ibid.*
[239] Peter Barham, *op.cit.*, pp. 293-299. Also see Joanna Bourke, 'The sufferings of "shell-shocked" men in Great Britain and Ireland, 1914-39,' *Journal of Contemporary History*, Vol. 35, p. 63; Edgar Jones, Simon Wessely, *Shell shock to PTSD: military psychiatry from 1900 to the Gulf War*, Hove; New York: Psychology Press, 2005, pp. 61-64.
[240] PIN15/2499.

> All around he sees tragic cases of incurable lunacy, and hears their demented cries night and day. So far as he can foresee his future, it is an eternity of horror among these unfortunate people. ... Over 6000 ex-service men are undergoing that mental torture in pauper lunatic asylums today. Many of them are curable, under specialised conditions.[241]

These provocative phrases prevented Robertson, who had spent his whole life in asylum services, from helping Milner's Society. In addition, the Milner's brochure suggested that they were willing to take over the role of curative treatment for mentally ill patients from psychiatrists. Hence, Robertson found in the brochure the 'rather extravagant character of Sir Frederick Milner.'[242]

Also, importantly, Milner remarked that 'the Ex-Service Welfare Society has opened a model home for treating such mentally broken ex-service men at Beckenham, Kent, and funds are urgently required to maintain it, and to establish similar homes throughout the country.'[243] This must have been seen by psychiatrists as threatening to their practices, since the Society declared its intention to extend its non-asylum service around the country.

Psychiatrists' dislike for Milner is also observed in an anecdote at the Society's party. Maurice Craig was invited to the opening ceremony for the 1920 project of the Society. Not only did he not attend, however, but he spread his absence around.[244]

Robertson did not relax his criticism over the Ex-Services Welfare Society. Rather, he reported his communication with the Society to the Ministry of Pensions that was supplier therapeutic hostels for invalided soldiers. In reporting, Robertson

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[241] *Ibid.*
[242] *Ibid.*
[243] *Ibid.*
[244] *Ibid.*

continued to condemn the Society as 'exceedingly ignorant of all that is being done for ex-service mental patients' by the Ministry of Pensions.[245]

However, Robertson offered help after finding out that the Society regretted the brochure and was anxious for his assistance. He introduced to the Society Dr. Carswell, the late Commissioner of the General Board of Control in Scotland and a consulting psychiatrist at Harley Street. Giving them this chance, he expected the Society to issue 'no more false and objectionable statements.'[246] By flaunting their advantages that they could introduce capable mental health employees, psychiatrists put the voluntary organisation into a position subject to them.

The outcome of the Society's contact with Carswell is unknown, but it probably ended in failure, for in 1925 the Society approached Edward Mapother, physician superintendent to the Maudsley Hospital, to be a consulting doctor to the hostel run by the Society.[247] The first reply of Mapother was, like Robertson and other psychiatrists, very frosty. In reply, he offered a brief consultation to the hostel by payment:

> (a) As to suitability for treatment in their home at Beckenhm or elsewhere;
> (b) On the point whether symptoms were from the standpoint of the Society sufficiently connected with military service to justify it in undertaking treatment.[248]

But he declined 'to enter into any controversy which they might have with either the Ministry of Pensions or the Board of Control.'[249] He stipulated that he should have 'no official connection with the Society and that no publicity of any kind should be given to my name,' because he was also furious that the Society had been 'entirely

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[245] *Ibid.*
[246] *Ibid.*
[247] PIN15/2501.
[248] *Ibid.*
[249] *Ibid.*

mistaken and misguided in the attitude they had adopted towards the Ministry, the asylums and the Board of Control especially in making attacks rather than seeking to cooperate and perhaps supplement official arrangements.'[250] The Society accepted Mapother's offer without any conditions.

As a result of its surrender to psychiatrists, the Ex-Service Welfare Society could survive in the late 1920s. In 1927, it had 20,000 applications and 8,000 interviews, and dealt actually with 233 patients. In this year, the Society collected £ 37,265 from a charity boxing tournament and garden party. The cost spent on the care and treatment was £ 15,130 in this year. This was almost the same amount of expenditure of the Cassel Hospital, a middle-sized voluntary institution.

In 1927, the Society became more actively cooperative with psychiatrists. It stated that:

> Various asylums have been visited in England during the year. Many of the inmates have received assistance in connection with their appeals for pensions. Advice has been given them and their families. The General Secretary paid a visit to the Asylum (St. Audrey's Hospital) at Melton, Suffolk, where ex-service men pensioner patients are in a ward segregated from the ordinary patients. The ex-servicemen appeared to be happy and contended. Suitable recreation was provided and the food was plentiful and of good quality.[251]

This evidences a triumph of consulting psychiatrists over an anti-alienist and economically competitive mental health provider. In this way, consulting psychiatrists defended and extended their practice.

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[250] *Ibid.*
[251] PIN15/2499.

A Black Market: Nursing Homes

Nursing homes were competitive counterparts to psychiatrists in their market in the 1920s, but their development has been unknown generally, probably because few documents are left. According to social policy researchers Caroline Woodroffe and Peter Townsend, nursing homes developed rapidly from the 1870s, and by 1900, 'there were 50 nursing homes in London alone.'[252] However, their actual practices remain uncharted.

In the early twentieth century, many nursing homes seemed to participate in the sphere of mental health provisions, since they were recorded as receiving nervous and mental cases in the advertisements of *Medical Directories*. For instance, the Caldecote Hall at Nuneaton accepted applications from those who suffered from functional nervous disorders both 'physical and mental.'[253] This nursing home was not licensed by the Board of Control. Moreover, the Archer Nerve Training Colony at King's Langley managed by Langley Rise Ltd. emphasized its provision for functional nervous disorder.[254] This disease was understood as the one targeted by psychiatrists for early treatment of mental disorder.

The nursing homes that appear in the *Medical Directory* seem to be the tip of the iceberg, given other sources about them. For instance, Sara Elizabeth White remarked that under the 1890 Act, the medical profession developed its nursing homes that provided treatment for mental and nervous cases without legal certification.[255] Moreover, as shown in Chapter 4, the Lunacy Commissioners exposed many cases in which nursing homes received mental patients without

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[252] Caroline Woodroffe and Peter Townsend, *Nursing homes in England and Wales: a study of public responsibility*, London: National Corporation for the Care of Old People, 1961. p. 7.
[253] *Medical Directory*, 1930, p. 2212.
[254] *Ibid.*, p. 2227.
[255] *Journal of Mental Science*, July 1920, p. 342.

licenses. In the interwar period, too, nursing homes' participation in mental health services was revealed in scandals of the abuse and ill-treatment of patients. In 1919, *The Times* reported a court case in which 'a paralysed woman who could neither walk without aid nor speak coherently' received imbeciles, epileptics and severe and certifiable mental patients into her unlicensed nursing home.[256]

Some medical critics suggested the necessity of state supervision and a register of nursing homes. In 1904 and 1925, at their insistence, the bills for the registration of nursing homes was introduced into Parliament, but failed. In 1926, a parliamentary select committee was appointed to consider the issue. In its argument, the medical profession was negative about the indiscriminate registration of doctors' nursing home businesses. Criticising the improper nature of nursing homes run by laymen, they resisted the registration of their own nursing homes because of their 'specialties and high professional ethics' of individual privacy. They also said that their nursing homes met increasing demands, whereas the layperson's homes did not. Hence, they opposed the state inspection of medical nursing homes.

Psychiatrists were more responsive to the issue. In the Parliamentary Committee of the MPA in 1922, Ernest W. White suggested the registration of nursing homes that dealt with nervous and mental cases, because of the illegal practices and abuses. They should, White argued, be supervised legislatively for the sake of mentally ill patients. Criticising non-specialist nursing homes, he was careful about doctors' insistence that the use of nursing homes was a matter of privacy and free will. He added that nursing home registration would cause 'no interference with the privacy of the patient.'[257] To avoid medical oppositions, he

[256] *Times*, February 20, 1919, p. 4.
[257] *Journal of Mental Science*, April 1922, p. 429.

confined his proposals strictly to the psychiatrists' own section.[258] To his suggestion, psychiatrists on the committee did not agree. The disagreement seems to show how prevalent was the medical and psychiatric interests in nursing homes.

Compromising the medical and psychiatric professions, the 1926 Select Committee recommended first that all the nursing homes register with county councils and county borough councils without exception.[259] The duties were to be taken by medical officers of health. However, local authorities should delegate their powers to a committee upon which both doctors and nurses should have representation.[260] Following this recommendation, Parliament enacted the Nursing Homes Registration Act in 1927.

In this Act, the mental health institutions under the Lunacy Acts and Mental Deficiency Act were exempted from the registration because they were already supervised by the Board of Control. However, interestingly, many of non-psychiatrist proprietors of nursing homes for certifiably mental patients were anxious as to whether they would be registered in the 1927 Act, and contacted the Board of Control and local authorities voluntarily.

Before the 1927 Act, a Commissioner of the Board of Control was aware that mental cases were being received at nursing homes.[261] He said that:

> I have no doubt the nursing homes will still continue to take borderline cases as they now do, but if the words stand I think they might claim much greater latitude than they are now allowed; indeed they might think the provisions of section 315 of the Lunacy Act, 1890, and section 51 of the Mental Deficiency Act, 1913, were abrogated.[262]

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[258] *Ibid.*
[259] *Report from the Select Committee on Nursing Homes (Registration)*, H.M.S.O., 1926, pp. xviii.
[260] *Ibid.*
[261] MH51/570.
[262] *Ibid.*

He was right on this point. Unexpectedly, after the 1927 Act, nursing homes themselves revealed that they received mental patients.

In April 1928, the Board of Control received a letter from Leonard S. Wilcox, a general practitioner in Brighton. On behalf of Mrs. Beverton at Hampstead, who received certified and uncertified mental cases of a chronic nature under the supervision of the Board of Control's Commissioners, he asked the Board whether she could claim an exemption from registration as a nursing home under the Nursing Homes Registration Act, 1927, because her home might be seen as an 'approved home within the meaning of the Mental Deficiency Act, 1913' that was not required to go through registration.[263] Wilcox was a visiting doctor for her patients. In reply, the Board of Control pointed out that her nursing home was not an 'approved home' within the meaning of the 1913 Act, nor was it possible for her institution to receive mental cases within the meaning of the 1890 Act.[264] Her reception of mental cases was accidentally found to be illegal.

In the same year, H. Scatliff, a general practitioner in Brighton, sent a letter to the Board to confirm whether he needed to take any steps in regard to registration under the 1927 Act because he had a certified patient, Mr. P. Gibson, supervised by the Board. Contrary to Scatliff's expectation, the Board found that Scatliff's house was neither approved under the 1913 Act nor was it an institution within the meaning of the Lunacy Acts.[265]

Local medical officers of health also found unlicensed nursing homes that had received mental cases. An inspector in Surrey reported in 1928 that Miss F.A. Eccles at Redhill received five patients domiciled at her home, four of who might

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[263] *Ibid.*
[264] *Ibid.*
[265] *Ibid.*

have been borderline cases.[266] In Bristol, too, the medical officers of health discovered that 'there appears to be a certain number of nursing homes who keep one or more mental patients, usually senile cases, and who are not under the supervision of the Board of Control.'[267] Indeed, a nursing home called The Wylands run by Mrs. Kate Hill accommodated three patients of unsound mind not under the supervision of the Board, and in the Sefton Nursing Home operated by Miss Muriel King held six mental patients.[268] As for Bristol's cases, the Board of Control paid a special visit and found 34 other certifiable psychiatric patients under its care. The matrons were sent to the Justices.

Even in the 1930s, the 1927 legislation caused the accidental discovery of unlicensed nursing homes. In 1938, the medical officer of health at Poole found 'the possibility of proceedings for illegal charge against Dr. W. V. T. Styles' at Bournemouth. Without any expert skill of psychiatry,[269] this doctor dealt at his home with an elderly female patient suffering from senile dementia, a male patient described as a case of "arterio-sclerosis and nerves," and a male described as recovering from mental breakdown.[270] The interwar competition in the psychiatric market underlay nursing homes businesses.

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[266] *Ibid.*
[267] *Ibid.*
[268] *Ibid.*
[269] William Vere Taylor Styles was the deputy medical officer of health at Bournemouth and assistant physician to Bournemouth Isolated Hospital. His medical interest was supposedly in child health *(Medical Directory*, 1938, p. 1120).
[270] MH51/285.

Psychoanalysis as a Medical Living

After the Great War, the psychoanalytic school participated in the mental health market. Historians of psychoanalysis usually explain its post-war rise in connection with a successful doctor Hugh Crichton-Miller (1877-1959) and his founding of the Tavistock Clinic which opened in 1920, and with other psychoanalytic clinics established in the 1920s, such as the London Clinic and the Medico-Psychological Clinic.

This was, however, rather informal, because psychoanalysts could not provide formal institutions for mental cases under the Lunacy Acts. For this reason, they were forced to conduct informal mental health practices. In previous histories, psychoanalytic clinics have been explained as charitable institutions. It may be true but, importantly, psychoanalysts could not actually raise enough subscriptions to cover their medical living expenses. At the Tavistock Clinic in 1939, Miller and 90 doctors provided psychotherapy for 30,000 hours per a year at the maximum fee of 5 shillings a visit.[271] According to these statistics, the Clinic could earn £ 7,000 maximum a year, but this could not meet the salaries for the working doctors. However, it did not have any specific and extravagant patrons.[272]

For this reason, psychoanalytic doctors needed to resort to private practices and nursing homes for income. Even Crichton-Miller at the Tavistock Clinic could not cover his living expenses, by only providing outpatients for early and milder casess. He needed to receive mental cases at his private premises. In 1928, he asked the Board of Control to allow him to establish a house to receive:

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[271] *Lancet*, January 10, 1959, p. 105.
[272] Suzanne Raitt, *op.cit.*, p. 71.

a. Patients whose certificates have been dismissed.
b. Patients who have been seen once in consultation, and whose certifiability is doubtful.
c. Patients who have developed noisy or hysterical symptoms, but whose rapid improvement is so probable as to render desirable a period observation before certification is resorted to.[273]

His wish was to open a nursing home for ten or eleven psychiatric patients at Hatch End, which would be actually run by Dr. Josephine Miller, his daughter, and her husband. This petition was clearly contrary to the 1890 Act's regulations, since it indicated that his house would receive all mental cases. In particular, his proposal (c) seemed unacceptable, since the 1890 Act had the urgency order system in which to render an observation period before certification. As supposed, the Board of Control rejected his petition because Miller's home was likely to evade the 1890 Act.

Half a year later, however, Josephine Miller sent a letter to the Board, saying that she had already opened a nursing home, receiving a very doubtful female patient as to her certifiability: Mrs. Rosa Watson.[274] The Board of Control did not admit her admission, because it doubted whether Crichton and Josephine Miller intentionally received certifiable patients.[275] Consequently, the Millers gave up receiving Watson at this time. But in 1930 when the Mental Treatment Act allowed the establishment of new institutions for early treatment of mental disorders, they applied for a licence under the Act and became able to receive voluntary and temporary patients. This unknown private practice of Crichton Miller shows that even 'charitable' psychoanalysts tried to encroach on the psychiatric market in the 1920s. Outside the Tavistock, they too pursued medical livings in the humanitarian name of early treatment of mental diseases.

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[273] MH51/287.
[274] *Ibid.*
[275] *Ibid.*

Conclusion

This chapter has examined psychiatrists' interests in the economic jurisdiction of psychiatry that was hidden behind the political claim for early treatment of mental disorder in the 1920s. In particular, it has focused on four important dimensions: the discourse of early treatment of mental disorder, the professional occupational structure increasingly dominated by psychiatric consultants, the institutional practice of voluntary admission, and the collaboration and conflicts between psychiatrists and other medical and lay agents interested in the psychiatric market.

Regarding the idea of early treatment, it has argued that in the 1920s, psychiatrists continued to base it on the grounds of preventive medicine and humanitarianism, as they had done since the 1890s. Behind the rhetoric, however, there was the secret commission to establish free market principles in psychiatric treatment, and to extend less legalistic treatment to non-volitional cases - apparently severe mental cases.

This chapter has also shown that the occupational structure of psychiatrists remained consultant-dominant. It has demonstrated how psychiatric consultants sought extensive control over private asylums, neurological hospitals and hostels for shell-shocked soldiers, as providers of wealthy patients. Through connections with these premises, they absorbed profits into their private practices, by recruiting potential patients through hospital appointments.

As in the 1890s, voluntary admission was still a managerial tool to recruit and keep patients in institutions; asylum critics in the 1920s penetrated the rhetoric of voluntary admissions. This admission system was exploited for the purposes of the jurisdictional expansion of psychiatrists. New in the 1920s, however, was the

case of the Harnett versus Bond and Adam in 1924 that provoked practitioners' fears about the economic risk in certifying patients, thereby inflicting a further and compelling reason to promote voluntary admissions.

This chapter has also shown how many non-psychiatrist doctors and lay entrepreneurs participated in the psychiatric market place in the interwar period. Facing this market change, psychiatrists endeavoured to exclude their rivals and corroborated with each other to effect this. They acquired vested interests at the Middlesex Hospital, the Cassel Hospital, and Frederick Milner's hostels for the shell-shocked, arguing for the promotion of the early treatment of mental disorder.

Overall, the entrepreneurial spirit of the psychiatric profession was, in many instances, behind the political campaign for the early treatment of mental disorder between 1890 and 1930. Despite their emphasis on humanitarian and preventive psychiatry, it should be reminded, psychiatrists, while promoting a progressive ideological move to mental hygiene, defended their market jurisdiction. The freedom of medical practice from the 1890 legislation and the necessity of the monopoly of the treatment were the issue that psychiatric doctors were continuously concerned about after 1890.

The 1930 Act implemented practical measures that would meet such psychiatrists' demands, whether it was recognised by statesmen or not. As mentioned above, the Act again enabled psychiatrists and lay proprietors to open new private premises for mentally afflicted people. As a result, in the 1930s, 17 private nursing homes were established for early treatment of mental disorder. The proprietors included, from the medical side, 2 public asylum superintendents, 5 private asylum superintendents, 4 practitioners, and 5 non-psychiatrists; in addition to these, 4 limited companies and 2 voluntary associations newly participated in the

mental health market.[276] In this light, the 1930 Act yielded practical benefits to medical and lay entrepreneurs that were economically interested in mental health provisions.

However, it should be reminded that the Act did not let them to thrive financially. Rather, they failed to establish a new niche in the market. The nursing homes, in the 1930s, occupied only between 0.1 and 0.6 percent in the private sector of mental health on the basis of patient's number.[277] Licensed 177 beds in 1939, for instance, they could receive only 89 patients.[278] The 1930s was certainly the age of voluntary admission. Private asylums maintained their commercial basis, by increasing voluntary patients, and public asylums did so. However, new nursing homes did not get popularity in the market, perhaps because users' demands for less legalistic psychiatric treatment were met by non-psychiatric nursing homes that spread in the 1920s, and because public asylums, in the 1930s, could provide voluntary and temporary admissions for potential middle-class patients who disliked legalism of Lunacy Laws.[279] At any rate, however, early twentieth-century English psychiatry smoldered with its desire for trade of lunacy.

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[276] Among them, psychiatrists who belonged to the MPA were Charles Hott Caldicott, Elizabeth Casson, Ernest Mannering Douglas-Morris, John Norman Glaister, Douglas Ian Otto Macaulay, John Macleod, Neil Macleod, Hector Duncan Macphail, Ernest Frederick Reece, C. J. Tisdall, Edward Lincoln Williams. Outside the MPA, Jeremiah Reidy, Charles Wilmott Henderson Newington, William Menzies Kirkwood Mclellan, Henry Llyod Driver, Neville Hood, Linzee were licensed for establishing psychiatric nursing homes. In addition, Messrs Arthington Ltd., Nynehead Court Ltd., and Fenstanton Ltd. were private companies that newly opened mental nursing homes in the 1930s.

[277] *The Annual Report of the Board of Control*, London: H.M.S.O., 1930-1939.

[278] *Ibid.*

[279] Non-psychiatric nursing homes were, it was largely confirmed by Commissioners of the Board of Control, very popular in the medical market in the 1920s. See the section of this chapter on nursing homes. Public asylums increased their voluntary admission from 830 in 1932 to 8,629 in 1939 (*Ibid*).

Conclusion

This thesis has examined psychiatrists' political strategies for securing their market in the period from 1890 to 1930, when the 1890 Lunacy Act restricted the private sector of psychiatry. In particular, it has documented how psychiatrists deployed the political rhetoric of the early treatment of mental disorder to counter the ill-effects of the Act. In doing so, it has challenged the histories of the profession that have read the 1890 Act as a disturbance to benevolent and scientific activities of psychiatric doctors. Deploying Abbot's concept of 'professional jurisdiction,' this thesis has instead interpreted the Act as an economic disturbance to the private sector of psychiatry that forced psychiatrists to construct a new occupational structure, institutional practices and political claims.[1] Historians have hitherto overlooked the extent to which senior psychiatrists economically resorted to the private sector, which held the lucrative ten percent of the mentally ill who provided more than two-third of their fortune. Such historians have focused on scientific researches, humanitarianism, and political ideologies of psychiatry, and on the micro-politics underlying psychiatric institutions and patients' experiences. In contrast, this thesis has sought to uncover the financial and market interests of early twentieth-century psychiatrists, arguing that these significantly framed modern psychiatry and its professionalism.

This dissertation has employed a variety of indirect forms of historical investigation, in the absence of documents revealing the financial concerns of

[1] Andrew Abbott, *op.cit.*

psychiatrists directly. It has demonstrated, for instance, how psychiatrists constructed their political rhetoric, by exploring logical setbacks underlying their practical interests for early treatment. From these, it has also sought to uncover the neglected structural changes of the profession in personal and institutional spheres. In other words, this study's method has been to reconstruct economic realities hidden behind rhetoric, and in this manner it has accounted for the professional politics of early twentieth-century English psychiatry.[2]

This approach might be applied to the study of English psychiatry in later periods, since psychiatrists continued to emphasise the therapeutic importance of early treatment, voluntary admissions and 'patient choice' as well as the stigmatising effect of the legalistic approach of the mental health legislation. In the political argument over the new mental health legislation of the mid-1950s, when the psychiatric regime was radically revised in the light of the psycho-pharmacological revolution and start of the National Health Service, British psychiatrists still pursued the policy of voluntary admissions without legal certification. In their view, legal admissions procedures would have a non-therapeutic and socially discriminating effects on the mentally ill population.[3]

Even today, the same rhetoric prevails in mental health politics. In July 2007, the Mental Health Act Amendment Act was passed after a protracted governmental campaign. The Act aims to reinforce compulsory admission measures for socially dangerous members out of the mentally ill population in the interest of public and community's safety. It also comes into line with the European legislation of patient's human rights. The 2007 Act, however, has been under severe criticism from psychiatrists, charitable organisations, patients' organisations, other medical

[2] The recent works on the history of English psychiatry have tended to concentrate on its local and institutional aspects. For example, see Joe Melling and Bill Forsythe, *op.cit.*, 2006.
[3] Kathleen Jones, *op.cit.*, 1991, p.154.

professions and groups, as well as opposition parties in Parliament.[4] The psychiatrists' opposition and political rhetoric draws on their traditional political resistance to legalistic measures for psychiatry. They insist that the law will impose policing requirements on the psychiatric services and thus discourage mental health users from resorting to them. Another problem has been this Act's wider definition of mental disease, a misleading move in the profession's opinion that would lead to more detentions in institutions.[5] Once again, the rhetoric of humanitarianism and the free market in mental health services are raised in the service of vested professional interests.[6]

Of course, the political circumstances of psychiatrists have been changed significantly through the twentieth century. But at least with respect to their rhetoric, continuities are apparent. In many ways what transpired after the 1890 Act looks more alike than different from today.

[4] For example, *British Medical Journal*, 30 June 2007, p. 334.
[5] *British Journal of Psychiatry*, Vol. 191, 2007, pp. 1-2.
[6] *Ibid.*, Vol. 183, 2003, pp. 95-97.