

The health and medical aspects of the famine in Tipperary

By Gordon Smith

Introduction

Given the massive loss of life that occurred during the Great Famine – an estimated 10% to 15% of the population, depending on various factors – it is perhaps surprising that many historians choose to look at aspects other than those related to health and medicine. From a medical point of view, however, there is no scarcity of records or sources. I will here focus primarily on those found in the British Parliamentary Papers, and on two documents in particular.

In the first section of the paper I will study the *Aspects of the most serious Representations made by the several Medical Superintendents of Public Institutions (Fever Hospitals, Infirmaries, Dispensaries, &c.) in the Provinces of Ulster, Munster, Leinster and Connaught*, HC 1846 (120), xxxvii (hereafter *Abstracts*). While it makes for interesting reading in its original form, I will be taking the reports apart, as it were, in order to calculate percentages and produce figures or statistics.

The second major source, the *Report of the Commissioners of Health Ireland, on the Epidemics of 1846 to 1850* (C 1562), HC 1852-3, xii (hereafter *Epidemics*) is equally worthy of comment, and will be dealt with in Part 2. Like *Abstracts* the emphasis is on a countrywide view, but for the purposes of this paper special attention will be given to data concerning Tipperary. In this way I hope to examine whether the relevant entries reflect the trends that appear and how they fit into the overall picture. Since both documents consist of prose for the most part, in general the approach used will be less qualitative than analytical, although both methods will be used.

Little time need be spent evaluating these two sources at this point, since I am only using the two named above. In general, since both documents originate from the Commissioners of Health they have merit by virtue of being contemporary accounts of famine conditions and of coming from “privileged” members of society, namely, doctors and medical officers. In any event, an evaluation will come through during the course of this paper. It would, of course, be wrong to take every word slavishly as irrefutable truth; there are pitfalls which I hope to address as I come across them.

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On 7 March, 1846 a letter was sent to the Lord Lieutenant on the subject of the apparent rise in disease throughout the country. It appears in the Parliamentary Papers as a preamble to the *Abstracts*.

Sir,

The Commission having given their deep and serious consideration to the last Reports from Medical Dispensaries, &c. in confirmation of the increase in Fever and Dysentery throughout the country, respectfully lay before his Excellency the accompanying *Abstracts* taken from those statements, and solicit his Excellency's attention to this alarming exigency.

The Commission do not venture to propose any distinct measure, but merely to urge the general necessity that his Excellency should have the means of directing medical inspection or attendance immediately as the localities require it, so as to avert the progress of disease, and adopt such other sanitary regulations as may secure the public health.

Accompanying this letter was an eight-page report collated from statements made by medical officers in dispensaries or fever hospitals in all four provinces. The report is in the form of a table with three columns: county and date of report; dispensary &c.; and nature of report.

There were 108 entries in all, though Carlow's space is left blank; so for the purposes of calculating percentages the figure I will use will be 107. As luck would have it, there are five entries for Tipperary (given below); this, in terms of the county's size and location, compares favourably with the rest of the country. They form about 11% of the data from Munster, or just under 5% of the reports from the country as a whole. Only Galway, Queen's County,¹ Waterford, Kerry, Limerick, Cork and Cavan have more entries than Tipperary.

no date	Clonmel Dispensary J. McDoutley, M.D., Surgeon	Typhus fever, the principal epidemic, is increasing, and attributed to the cold and moisture of the season.
February 21, 1846	Carrick-on-Suir Dispensary and Fever Hospital John Purcell, Esq.	Fever very much on the increase. Fever and dysentery prevalent in district, and attributed to the use of white potatoes, and uncleanly habits of the lower order of the population. A very great number of unemployed in district. Fever certainly anticipated.
February 20, 1846	Thurles Fever Hospital M. J. Quinlan	Fever more prevalent in this district for last few months than usual. Number of patients much increased from constant rain, insufficiency of food, and bad covering. Labouring classes wretchedly off for want of employment. Fever of a malignant type apprehended as consequent on the approaching famine.
no date	Fethard Dispensary R. Biggs, M.D.	Has serious fears that disease will break out with much severity, from scarceness of food. Suggests the building of a fever hospital, which is much required, he having three cases of fever lying in one bed.
February 18, 1846	Borrisoleigh Dispensary E. W. Pinchin, Esq., Surgeon	Diarrhoea appearing during last fortnight from the use of bad potatoes, a great increase of fever apprehended. ²

The report appears to be quite thorough, on the face of it, with returns from 26 counties, only the Carlow entry being blank. Entries from Munster and Leinster dominate, with 77 out of 107 (72%) from these two provinces. The timespan in which these reports were dated is a little over two weeks, the earliest given as 13 February 1846 and the latest as 28 February in the same year, so trying to survey a possible escalation of disease within such a short space of time would be fruitless. None of the entries for Leinster is dated, however – nor indeed are two of

the returns from Tipperary – but as the reports are so similar to those from other areas of the country, we can safely assume that they come from the same period.

The second heading varies from province to province. In Munster it is "Dispensary &c.," in Leinster it is "Fever Hospital, Gaol &c.". In fact these descriptions overlap, because dispensaries are not confined solely to Munster, nor fever hospitals to Leinster only; the examples from Tipperary illustrate this. The heading for Connaught reads simply "Return from Medical Officer". Most of the entries, like those given above, indicate what kind of public institution is in the area.

Conversely, in some cases the name of the town or village only is given, with no clue as to the kind of medical facilities available in the locality. Curiously, this is the case for all 13 reports from Ulster, where the heading is "District". To judge from the "nature of reports" column, this province was worst off in terms of having fever hospitals and the like, since a number of entries contain requests for them. Dr. Biggs at Fethard Dispensary made this same request; see above.

Since this paper is concerned with a medical view of the Great Famine, it is only right that the expertise of the Irish medical profession should be established. As it happens, Ireland's medical resources were on a parity with, if not better than, most of her European contemporaries.³ A province-by-province breakdown of medical supervisors shows that in Leinster, 56.2% were qualified doctors along with 37.7% in Munster, 64.7% in Connaught and 61.5% in Ulster.

Some others were surgeons, like E. W. Pinchin at Borrisoleigh, although there were cases where the two combine, such as Dr. McDoutley in Clonmel. In actual fact Tipperary was above the average in terms of having qualified medical personnel.

It is apparent from their returns that all had at least a fair idea of the kinds of sicknesses and disease which were becoming more prevalent, inasmuch as they were able to recognise the symptoms. In addition, fever and its associated diseases were obviously commonplace enough for there to have been a reasonable amount of fever hospitals already in place. Of the 107 entries, 19 came from fever hospitals, all located in Leinster and Munster.

Again, Tipperary was well serviced in this regard, since two of the five reports come from fever hospitals. The situation is best summed up by stating that while the personnel were quite well qualified, their facilities could have been improved on. This is said with the benefit of hindsight, however, and Froggatt rightly makes the point that Ireland was adequately equipped to deal with a typical subsistence crisis, "except, of course, for what actually came".⁴

It goes without saying that the Great Famine was not just a typical subsistence crisis; a decline in population of over two millions is testimony to that. There were other factors at work, such as emigration, aborted natural births, and the cholera epidemic of 1848-50; but death by fever, starvation and its related diseases was the largest single factor.

Yet the fact remains that in early 1846, just a few months after the first wave of potato blight hit the country, there were those who were predicting that worse was to follow. Many of the reports contained warnings or fears as to how disease would increase. Seventy-six out of 107 – a massive 71.02% – gave a prediction as to what would happen if the situation was allowed to continue. Their words were remarkably prophetic, and if anything underestimated the actual outcome.

The one heading in the report that is of most interest is that of "nature of report". The examples given earlier are typical in style and content, with length varying arbitrarily, some reports being more detailed than others. Overall, the pattern is similar, with some description of diseases, along with a brief comment on poverty or unemployment in the region, suggested causes, and often a prognosis as to how the writer felt the situation was going to develop.

It becomes clear after reading a few of these reports that they have been edited and that what appears amounts to a *précis* of a presumably longer report. Indeed, the letter preceding the *Abstracts* says as much. All the entries are in a similar style and all are in the third person singular – this despite the medical superintendent's name being given alongside each report. Stock phrases appear again and again, such as “many of the poor unemployed”, or “an outbreak of disease generally apprehended”.

This section of *Abstracts* establishes three basic truths of the famine – the widespread (and quite varied) diseases; poverty and unemployment; and the dependence of many on the potato. Much of these facts have been unearthed since by historians, but here they are available at the source, so to speak, by contemporary witnesses and in many cases they are linked.

The returns from Borrisoleigh and Fethard dispensaries are good examples of this, rightly associating the lack of good food with an increase in illness. The table below, compiled from the 107 reports, gives a rough breakdown of diseases throughout the country. As there was some dispute over exact diagnosis (and this was at an early stage of the course of the disease, after all) the “fever” column encompasses typhus fever, “low” fever and other forms, for the sake of simplicity. The “other” column is an amalgam of the general term “disease” which sometimes appears, or specific (but rare) disorders like scarlatina or dyspepsia.

	Ulster	Munster	Leinster	Connaught	Total
Fever	9	32	12	8	61
Diarrhoea	5	7	6	2	20
Bowel Complications	4	6	10	4	24
Influenza	3		1		4
Dysentery	1	8	6	2	17
Other	7	10	9	3	29

In this form, the figures speak largely for themselves. The high return for stomach-related illness would appear to indicate malnutrition or poor eating habits, a point I will be picking up again. Surprisingly, influenza is quite limited to its effects here, concentrated in Ulster, and not reported at all in Munster or Connaught. Although one risks stating the obvious, these figures do not take into account the unreported cases of those who did not make it as far as the fever hospitals or dispensaries for treatment.

The theme of poverty also becomes evident on even the most cursory reading of the document, and this is naturally linked with the problem of unemployment. In addition to remarks about destitution and general poverty, almost half of the reports (47.6%) contain comment about the lack of work. Some typical examples are: “many unemployed poor”, “fully three-fourths of the labourers unemployed”, or “suggests immediate employment”, which means the same thing by implication.

A logical follow-on from unemployment was a lack of money to buy foodstuffs other than potatoes, which formed the staple diet of so many at the lower end of the socio-economic scale. Gearóid Ó Tuathaigh notes: “given the nature of the Irish economy, a major failure of the potato crop meant, of necessity, a major crisis”.⁵ Again, contemporary evidence of this is provided in the *Abstracts*. In naming causes for the outbreak of disease, many of the entries

correctly cite "unsound potatoes". This stock phrase features regularly in the reports, along with "unsound food", which for all practical purposes means the same thing, since the diet of much of the population was potatoes anyway.

"Bearing in mind the great and growing reliance of large sections of the population on potato crops, it seems clear that famine was almost endemic in Ireland in the thirty years or so before the Great Famine".⁶ The *Abstracts* back up this point about Ireland's vulnerability to famine; the reports suggest its related diseases, such as fever, were prevalent before 1845. As noted, the reports show that the medical superintendents recognised symptoms of familiar illnesses, and the significant number of fever hospitals already in place in Ireland leads to a similar conclusion.

In support of this Froggatt writes: "typhus and relapsing fevers, smallpox, tuberculosis, dysentery, marasmus (starvation) and other famine disorders – were familiar being endemic in Ireland ... it was therefore old if dangerous friends the [medical] profession would encounter".⁷ One entry refers to an earlier subsistence crisis, and the resulting disease. Some reports gave other reasons for the prevalence of illness, stating that unsound food was not the cause; but these go no further and are very much in the minority.

To summarise, what emerges is a very bleak picture of poverty, scarcity of food, widespread disease and the beginning of an overcrowding problem at some of the medical institutions, with hints that the facilities might not be able to cope with the demand. (Dr. Biggs's entry from Fethard made the latter point.) As a contemporary account from qualified and reliable sources, the *Abstracts'* accuracy would seem to be beyond reproach and it would be tempting to leave it at that.

However, I believe that valuable though this document is, it does not show the complete picture. Earlier I hinted at this possibility. The fact that reports from six counties do not appear is not unduly suspicious by itself, but of the 107 entries only two come from county Dublin, and even they could not be called representative, coming from Saggart and Rathcoole Dispensary and Rathdown Fever Hospital. Froggatt's study of the medical profession during the Famine gives some interesting statistics: there were 101 fever hospitals all told in 1845, and 664 dispensaries.⁸ Even allowing for unreturned or mislaid reports, the discrepancy is too big to ignore.

The word "abstracts" itself is another way of saying that the report has been edited, a fact referred to already, and I would contend that they have been fairly judiciously edited. The phrase "most serious representations" means exactly what it says, but what is implied is that these extracts have been chosen from a wider range and that what is being presented is a very specific cross-section of these.

I have already noted the qualifications of many who filed the returns. The fact that "medical superintendents" is highlighted in block capitals in the title gives the whole thing an air of importance, weight and especially credibility; these are not just the views of the man in the street. Lastly, the names of provinces are also written in capitals, emphasising that this was a countrywide epidemic.

In short, all this leads to the conclusion that *Abstracts* is in fact a cleverly constructed argument. If further proof were needed, it should be pointed out that the edited version was produced not by Dublin Castle or the London authorities, but by the medical profession themselves, or more precisely the Commissioners of Health. The accompanying letter (printed near the beginning of this article) bears this theory out. It is also worth pointing out that the worst case of potato blight was still seven months away at this time, and that while disease features prominently in the returns, death is rarely mentioned.

As to the purpose, one can only guess. Judging from the reports themselves, there are a

number of requests for better medical facilities, fever hospitals in particular, and it could be that the intention was to earn some sort of grant or extra funding for the profession. There were a number of smaller subsistence crises in the years leading up to the Famine, and perhaps it was thought that advantage could be taken of the circumstances to request aid.

MacArthur makes an interesting point which ties in with this line of thinking. Almost a month to the day after the last return for *Abstracts* is dated, a Temporary Fever Act was passed on 24 March 1846.⁹ The legislation was allowed to lapse during the following August, "a lamentable act of official misjudgment", according to MacArthur.¹⁰ A tragic case of crying wolf, perhaps? This view is, in fairness, quite cynical, though I think I have shown that there are grounds for it. On the other hand, the many suggestions about providing employment or grain and other food to indicate a more altruistic side to the profession.

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Epidemics is preceded, like *Abstracts*, by a letter, this time from the office of the Lord Lieutenant. In effect the report is a reply to a request made for the views of the Commissioners on the Famine. *Epidemics* is 42 pages long, comprised largely of text but also including tables.

Two appendices are included. Appendix A, the longer of the two, consists of forms, circulars, orders and returns under the Temporary Fever Act. Appendix B's contents come under the Nuisances Removal and diseases Prevention Acts. I mention these now as I propose to concentrate on the main report itself in this section.

Epidemics treats of the Famine under a series of headings: Fever, Smallpox, Food, Fever Hospital Accommodation and Cholera, and I shall examine the report in the same order. The first part gives a very brief history of the progress of the Famine, touching on all the major elements, such as the link between scarcity of food and fever and the course of the blight attacks on the potato crop. The legislation enacted to enable the Commissioners to provide medical relief is mentioned. The synopsis draws a parallel between the high price of potatoes and general poverty; this echoes points made in relation to *Abstracts*.

It will be remembered that *Abstracts* contained a number of requests for fever hospitals; this trend is continued in the following years. The report states that February 1847 brought a notable increase in applications, and a table showing the monthly breakdown of figures is included. In all, there were 576 applications made by Relief Committees or Boards of Guardians of which 373 (64.7%) were successful. Before coming to any conclusions I think it is fair to assume that a requisition for a fever hospital equates with a prevalence of fever in the district, although this is not conclusive by any means.

The report also contains a copy of an application for certificate of the Board of Health, under section 2 of 10 Vic., cap. 22. Point six reads: "Extent to which Fever or other Epidemic Disease prevails in the Electoral Division or Divisions to which the application relates; stating as nearly as may be, the number of cases which are not in any Hospital".¹¹

The writer¹² of the report came to the same conclusion: "The dates of the requisitions for hospital or dispensary relief may be considered as indicating, to a certain degree, the rise and progress of the epidemic in different localities".¹³ As regards Tipperary, the table referred to above lists 22 requisitions for fever hospitals - 5.6% of the total figure - well above the average. The requisitions came from six Union Districts: Carrick-on-Suir (one requisition), Clogheen (six), Nenagh (seven), Cashel (one), Roscrea (three) and Tipperary (four). The earliest date for application was 14 April 1847; eight requests were made the following month within the space of a week (17-24 May), eleven between 4-24 June, and lastly two in mid-July.¹⁴

Taking all of this into account, it would seem that fever was at its height in 1847. A general pattern emerges showing that the disease was most prevalent in the first half of the year between February and May, and that it fell steadily in the summer and autumn, a factor which was possibly due to improved weather conditions. The exception to this was in July 1847, when the number of applications topped the scale at 60, just over 10% of the total.

The data above for Tipperary is thus very typical of the overall trends. Figures declined sharply over the next two months, when it fell back into a pattern similar to subsequent years. Figures peaked slightly again in November in both 1847 and 1848; this may have been related to the onset of winter. No corresponding figures for 1849 were given.

Patient mortality in the fever hospitals is also commented on. Between July 1847 and August 1950 reports were made to the Commissioners on a weekly basis,¹⁵ and from these it emerged that 332,462 people were treated in the 373 hospitals provided for by the Board of Health. Of these, 34,662, or just over 10%, died. Slightly more women than men were treated; 173,723 as against 158,739, but the male mortality rate was higher: 17,800 (11.2%) compared with 16,822 (9.6%).¹⁶

The writer was at pains to dispel the idea that the mortality rate for fever was lower among those who had not been treated in hospitals – an idea which may have been put about by the Board's critics, of which there were certainly some.¹⁷ This apparent anomaly was explained by the fact that deaths that occurred in hospitals were invariably registered, whereas those which happened elsewhere were not. The writer does acknowledge that certain regions and periods had mortality rates that differed (sometimes widely) from the average. In an attempt to get at the causes, a circular was forwarded to medical officers in charge of hospitals where the mortality rate was 15% or higher.

What resulted was a table covering six pages which bears some similarity to the abstracts in terms of form and style. The entries were organised in descending order of the mortality rate percentage. Significantly, Nenagh came eighth out of 35, with a mortality rate of 366 out of 1,441; a little over 24%. A Dr. Quin put this down "chiefly to the overcrowding of the hospital, and to very many of the patients being pauper children from the workhouses, who were carried off by a complication of diseases".¹⁸

In fact the region around Nenagh would seem to have suffered particularly in this respect; a return from Dr. Stoney at Borrisokane, which was located in Nenagh Union, was fifteenth, with a rate of 20.3% or 55 out of 269. Here the deaths were attributed to "patients being attacked by both Fever and Dysentery, and subsequently by Cholera".¹⁹ Cholera was also blamed for patients' deaths at Clogheen (Dr. Galloghy) where 49 out of 293 or just under 15% passed away.²⁰

Pages 12 to 16 of the Commissioners' report quote from inspectors and medical officers in all four provinces. The object behind this was to ascertain the extent and exact nature of the disease at various times during the famine. The only entry referring to Tipperary read as follows:

*County Tipperary, Nenagh Union, Nenagh, 11th December 1847 (Dr. Burton) – Fever here appears to be of the short relapsing type in two-thirds of cases, the remainder spotted typhus; usual duration of attacks four, five or six days; head symptoms, pains in the joints, and hands, and tops of fingers, were very common; scarlatina occurred in a few instances; on an average more females than males have been attacked in this locality; bad or deficient food in all instances may be considered the causes of fever of short type.*²¹

The Dr. Burton who submitted this report seems to have travelled a great deal, certainly during late 1847 and the early months of 1848, mainly in Munster and Leinster, judging from

where the reports were filed. On 21 November 1847 he was at Tralee Union, Dingle. Nine days later he put his name to a report from Kilmallock Union in Co. Limerick. It was from here that he moved on to Tipperary, and three days before Christmas he visited Tullamore. The final entry attributed to him comes from Ballylinan, Athy-Union, County Kildare and it is dated 4 January 1848.

Generally, the majority of reports appear to have been filed by travelling doctors and medical officers; the case of Dr. Burton is illustrative of this, and the same names crop up regularly from different locations. This allows comparison between two districts which would be based on the same criteria. This is an important point because, as MacArthur remarks, in spite of the general expertise of the medical practitioners, a totally accurate diagnosis was not always guaranteed.²²

The report's writer reached the broad conclusion that the severity and particular nature of the disease could be attributed to the weakened state of the patients from famine, and consequently starvation. The writer also states that the total mortality rate was 42.2%, and emphasises the unusually high number of children who died – nearly 10% of the total number. Again, these calculations come from reported figures only, a point that cannot be stated often enough.

Perhaps surprisingly, there are not details given of treatment of disease. At the same time, it has to be said that *Epidemics* has a largely administrative slant on it, given the number of circulars, tables and statistical information which are included, and the observation that the document was aimed at prevention rather than cure is possibly a sound one. The writer explained, surely somewhat bizarrely, that "details of medical treatment being matters purely professional, would not, perhaps, properly come within the scope of this report".²³ The next section of *Epidemics* deals with smallpox and demonstrates the Commission's desire to leave no stone unturned in looking at the Famine. A short section, it contains no reference to Tipperary.

The next section is possibly the most interesting in the entire document, certainly for the modern reader, since it dispels some myths surrounding the Famine. The subject is food or, to be more exact, the link between food and disease. The writer contends that even if a grain product had been widely available to replace the potato, disease would not have been eradicated; far from it.

He elaborates on this, citing the potato's uniqueness as a foodstuff. "Although affording an inferior nutriment in proportion to the bulk consumed, from its consisting of about three-fourths water, it nevertheless contains in its composition nearly all those elements of nutrition that exist separately in most other vegetables and grain, and are, therefore, only to be obtained from most other articles of food by combining together different kinds".²⁴

To judge from the report, it seems that people were mistakenly replacing the potato with another single foodstuff, often rice, in the mistaken belief that it was enough to live on by itself. Extracts from Board of Health circulars were reprinted here, warning against some of the common misconceptions about grain food. The Board were not against the use of rice *per se*, but were adamant that certain guidelines be followed. They were wary of the presence of starch in rice; when boiled, this created the illusion of a greater mass of nutritious food.

Reliance on this actually lowered resistance to disease, and the end result was "increased expenditure in the cost of relief, instead of saving".²⁵ Another point made was that oatmeal had the same nutritive quantities as Indian meal, so a substitution of one for the other in poor relief rations should be equal, not lessened. An unbalanced diet could result in scurvy, even among those earning enough money to buy apparently good food. Scurvy seems to have been at its height in the summer of 1847, since a circular on this subject was distributed on 21 June of that year. Its purpose was to correct the belief that scurvy could be traced to deficiency of quantity; it was actually due to a lack of variety or quality in the food.

Also highlighted in the same circular was the need for the inclusion of vegetables such as onions, leeks, carrots, turnips and cabbage with meal, while it was recommended to complement rice with beans, peas or lentils. The typical notion that Indian meal of itself would act as a kind of panacea was stated to be groundless.

During the Famine the Board of Health were in contact with the Relief Commissioners and Boards of Guardians on this subject. The primary concern in this respect was that food should be cooked. A pertinent reason for this was that the practice discouraged the sale of raw meal, which amounted to exploitation of the poor. It was intended chiefly to decrease the risk of diarrhoea and dysentery, which were caused by the consumption of raw (or worse, badly cooked) meal. In outlining the causes of disease in *Abstracts*, the reader will recall that the phrase "unsound food", or similar words effect appeared regularly. While Indian meal was probably not available at that time, the same principle applied: bad food would cause disease just as surely as a lack of food.

On page 23 of the report a table gives the quarterly prices of wheat, oats, oatmeal and potatoes between 1845 and 1850. The aim here was to establish the link between scarcity of food and the prevalence of fever. In 1847, 1848 and for much of 1849 prohibitive prices left the poor unable to purchase what presumably would have been the few sound potatoes around. Against this were placed the admission figures for temporary fever hospitals which were, on average, 97,802 for the years 1847-49.

During the latter stages of the crisis potato prices had dropped, but they were still a good deal more expensive than in 1845. This was offset by the fact that oatmeal was now available. This was much better value, not because it was cheaper, but because it contained four times the nutriment of its equivalent weight in potatoes. Although weight for weight oatmeal was twice as expensive as potatoes, paying the same price for less oatmeal still provided a foodstuff that was twice as nutritious.

The writer remarked: "The people were not slow in discovering that the advantage in economy and nutriment was on the side of oatmeal".²⁶ The hope was expressed that the Irish could be weaned off potatoes and on to grain food. The arguments used were (and are) quite convincing. Essentially the advantages were threefold: it would reduce or remove reliance on a foodstuff which had been prone to infection; it would replace that foodstuff with one more healthy and nutritious; and, perhaps most importantly, it was cheaper.

The penultimate section of the report concerns fever hospital accommodation. The writer states at the outset that the 373 applications for hospitals were an unnecessary amount. A number of reasons were put forward to back up this line of thinking, chief among them being excessive cost. It was the Board of Health's initial intention that, where hospital accommodation was needed for neighbouring districts, one hospital centrally located could suffice, with provision for adjustment if required. Looking back at the data quoted earlier, it can be stated that Tipperary would have lost out in this regard.

As it happened, the very legislation enacted prevented the Board's advice from being heeded. "The amended Fever Act of April, 1847, clause 2, authorised the Commissioners of Health to issue certificates requiring hospital relief to be afforded in electoral districts; but only according as the necessity for it arose in each electoral district; the Board was thus precluded from directing hospitals to be erected in the first instance in central situations".²⁷ In addition, some relief committees refused for various reasons to unite to build a central hospital.

For the most part, existing fever hospitals had to be enlarged as there was a general scarcity of buildings which could be adapted. To this end George Wilkinson, the architect of the Poor Law Commission, was asked to provide plans for fever sheds and wooden bedsteads "of a very

simple and economic construction, which were found fully to answer the purpose".²⁸ The accompanying letter from George Wilkinson outlining the cost of the operation is dated March 1847.

Although the financial arrangements for the fever hospitals did not come under the auspices of the Board of Health (a factor that MacArthur attributes to flawed legislation),²⁹ a report was compiled from the financial returns of the Poor Law Guardians and the Relief Committees. The Board sent this to Parliament in 1850. Clerks of Unions in which these temporary fever hospitals were established sent returns of expenditure to the Board, and it emerges that the average weekly cost was 4s. 01/2d. per patient, a sum which included the salary of the medical officer.

The final part of *Epidemics* deals with cholera. This might seem surprising since, as Froggatt writes: "the cholera epidemic of 1848-50 ... was part of a general European pandemic ... whose arrival in Ireland (by way of Belfast on 1 November 1848) and its spread, though not its lethality, were largely independent of the famine conditions."³⁰ Indeed, Froggatt cites this very reason for not examining the topic in his own article. This document was primarily concerned with the diseases that were prevalent during a five-year period – the title tells us as much – and the fact that they occurred against the backdrop of the famine was important because it provided some causes for the diseases.

My main concern here is the Famine too, but since cholera was dealt with in *Epidemics* it deserves some comment here also. In addition, it is one of the few sections of the report that goes into any kind of county-by-county detail, and therefore provides information on Tipperary. The disease was to be dealt with under the provisions of the Nuisances Removal and Diseases Prevention Act. The fact that it merited its own legislation and its own section in the report is another reason to view cholera apart from the other epidemics.

On page 20 of the report there are two tables. The first gives a monthly list of cholera cases from December 1848 to August 1850. From this it is clear that the epidemic was at its most potent in 1849, peaking in May with 11,129 cases reported, dropping rapidly in the remaining months so that by October the cases numbered in the hundreds rather than the thousands.

The second table establishes the sexes, ages and premonitory symptoms of those affected, as well as giving the dates of the first and last cases. More women than men were afflicted; 25,697 to 20,001, from a total figure of 45,698. The mortality rate was quite high – 42.3%. The date of the first reported case was 4 December 1848; the last was exactly 20 months later on 4 August 1850.

The thorny issue of contagion was also addressed here, specifically concerning cholera. While admitting that the question was still "enveloped in great obscurity",³¹ the writer came down on the side of those who believed that the disease was not contagious, and attempted to establish this fact. Pages 39 to 41 contain extracts from some replies to a circular which was intended to ascertain the nature of the spread of cholera. Thirty-seven replies were received in all, of which eight were doubtful, six affirmed contagion and twenty-three disagreed.³²

This epitomises one of the chief pitfalls of primary sources, namely the temptation to take everything at face value. MacArthur was of the opinion that cholera was contagious, and observed that the Board of Health's stance was influenced by the view of their London counterparts who, he alleged, had come to this conclusion rather unconvincingly anyway.

A contemporary of the Board members, Dr. Graves, argued strongly that cholera in fact was contagious, and his advice was "wisely" acted on by many local health committees.³³ With the benefit of a century's hindsight and advances in the study of medicine the argument comes down in MacArthur's favour. This incident also hints at the animosity and criticism often directed at the Board of Health by prominent Irish medical men of the era.

Still, credit must be given to the Board for not trying to dodge the issue. Their stated aim was to look into preventative measures during a subsistence crisis, and the subject of contagion came up. They can hardly be blamed for holding to a theory which was quite prominent at the time.

Also in this section is a five-page table, listing all the towns in Ireland of 2,000 or more inhabitants, the total population, the number of cases and deaths (if any), the mortality percentage rate and the dates of the first and last cases. As well as confirming Froggatt's assertion that cholera was first contracted in Belfast, there are eleven entries concerning Tipperary.

Cholera here seems to have been very widespread; of the towns that fit into the above category, only Cashel (population 8,027, ironically one of the highest in the county and centrally located) escaped. The affected towns were: Clonmel, Nenagh, Carrick-on-Suir, Thurles, Tipperary, Roscrea, Fethard, Caher (*sic*), Templemore and Clogheen. The first case in the county was reported on 22 March 1849 at Nenagh and the last at Thurles over a year later on 10 June. This last date is out of kilter with the rest of the county, which was most affected in the Summer of 1849, in keeping with the general pattern of the disease established above.

In terms of mortality, however, Tipperary was particularly badly affected. Out of 2,218 cases 1,093 were fatal – 49.2%, nearly 7% above the national average. Of the ten towns listed, Templemore was the only one to register below this average.³⁴ Taken from these and the rest of the figures is a cholera map, a fold-out document indicating the affected towns and those not visited by the disease.

Summing up, the report's writer noted that all that could be done to counteract the disease was what was already in place. There was "nothing to alter or modify in the advice given in our circular of the 1 September 1848, with regard to future arrangements".³⁵ This could be interpreted as another way of saying that the Board had learned nothing new from the visitation of cholera; but that might be too harsh. Their aim was to provide "prompt dispensary attendance for the sick poor who may wish to remain in their own homes, and hospital accommodation for those who stand in need of it".³⁶ It seems that the Board was conscious of its public image.

Domestic visitation was advised against because it appeared too much like "prying inquiry",³⁷ and because of its inefficiency. Also to be feared were the occasional rumours that the medicines administered by the travelling medical inspectors were the cause rather than the prevention of death. The final paragraph reads:

We have therefore only to advise in respect to future arrangements, that in the event of a visitation of Cholera, the greatest facilities for medical relief should be represented by providing Dispensaries and Hospitals to afford by night as well as by day, the promptest attendance on all applicants, and that the greatest publicity should be given in posted notices of the situation of such Dispensaries and Hospitals.

We have the honour to be,
Your Excellency's
Obedient faithful servants,
Philip Crampton.
H. Marsh, M.D.
D. J. Corrigan, M.D.³⁸

– 3 –

Since the first part of this article is largely self-contained, I propose to discuss briefly the aims behind *Epidemics* in conclusion. What I hope has come across was that the report was

essentially administrative rather than practical. True, there were extracts from medical reports going into some detail; but these were used to back up points made rather than as points in themselves.

Another aspect which may have been clear is the preoccupation with money, or more precisely economy. The Board of Health were concerned to avert widespread disease in the future; yet one cannot help but notice a desire to do so as cheaply as circumstances would allow. It is unclear whether this was the thinking of Board members themselves, or whether it came from above.

In essence the report is a famine management handbook of sorts; a guide to handling a subsistence crisis in an efficient manner. The document itself is extremely thorough, as becomes clear from reading the second section. Any disease that occurred between 1845 and 1850, whether related to the Famine or not, merited examination; hence the references to smallpox and cholera. The use of extracts from medical reports was twofold; it helps to give a potted account of the actual Famine, and also to show that (most of) the measures suggested by the Board were not simply theoretical but would work in practice.

The references to the legislation enacted during this period in the text again support the idea of *Epidemics* as an administrative document, and hint at the "target audience". Considering who would have been reading this report, it is fair to suggest, I think, that much of the advice of the Board contained in it would have been acted on in the event of a future subsistence crisis. Interestingly, on a number of occasions since the Great Famine, notably in 1859, 1864 and 1879-80, potential famines were kept at bay by the importation of meal from India, which would seem to lend weight to this interpretation.

As for Tipperary's place in all of this, the county escaped few, if any, of the ravages of the Famine. If any consolation may be drawn, it might be from the fact that the information from the region in some way aided the Board of Health – and by extension the modern reader – in establishing a clearer picture of what happened during those fateful years.

However, it should be stressed that even the surviving accounts cannot allow for the many aspects of the Great Famine that went unreported. But, given that so many never made it as far as any hospital, it is doubtful that any one document ever could.

FOOTNOTES

1. I refer to counties and spelling etc. in the older forms given in the report.
2. *Abstracts*, pp. 5-6.
3. Peter Froggatt, 'The response of the medical profession to the great famine', in E. M. Crawford (ed.), *Famine: the Irish Experience 900-1900*, Edinburgh, 1989 (hereafter, 'Froggatt').
4. Froggatt, p. 136.
5. Gearóid Ó Tuathaigh, *Ireland before the Famine 1798-1848* (Dublin, 1987), p. 207.
6. R. D. Crotty, quoted in Peter Solar, 'The great famine was no ordinary subsistence crisis'; in E. M. Crawford (ed.), *op. cit.* pp. 112-13.
7. Froggatt, p. 135.
8. Froggatt, pp. 136-7.
9. Sir William MacArthur, 'Medical history of the famine', in R. D. Edwards and T. D. Williams (eds), *The great famine: studies in Irish history 1845-52* (Dublin, 1976), p. 290.
10. MacArthur, p. 290.
11. *Epidemics*, p. 5.
12. For the sake of simplicity, I refer to 'the writer', although the report is clearly the work of more than one hand.
13. *Epidemics*, p. 3.

14. *Epidemics*, pp. 60-66.
15. *Epidemics*, p. 4.
16. These figures are based on my own calculations, using the data in the report.
17. Froggatt.
18. *Epidemics*, p. 7.
19. *Epidemics*, p. 8.
20. *Epidemics*, p. 10.
21. *Epidemics*, p. 13.
22. MacArthur, p. 288.
23. *Epidemics*, p. 16.
24. *Epidemics*, p. 18.
25. *Epidemics*, p. 20.
26. *Epidemics*, p. 24.
27. *Epidemics*, p. 25.
28. *Epidemics*, p. 26.
29. MacArthur, p. 297.
30. Froggatt, p. 135.
31. *Epidemics*, p. 41.
32. *Epidemics*, p. 39.
33. MacArthur, p. 307.
34. *Epidemics*, appendix 1.
35. *Epidemics*, p. 41.
36. *Epidemics*, p. 41.
37. *Epidemics*, p. 42.
38. *Epidemics*, p. 42.