

## (Re)Creation

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## **(Re)Creation**

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# Pathways and Practice: The General Practitioner in Nineteenth-Century Dundee

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*Although the care of the basic medical needs of much of the population, or what might be termed general medicine, accounted by the mid nineteenth century for the work of the majority of medical men in Britain, those who practiced within this field were an irregular group of practitioners who had evolved from the surgeon-apothecaries and man midwives of the eighteenth century, and who formed an unspecific mix of medical men with different qualifications, training and experiences. Increasing legislation forced the radical development of the medical profession by the end of the century and, in a changing climate of education and opportunity, medical men competed for professional survival. This they did through the cultivation and exploitation of 'community niches' to gain professional recognition (Digby, 1999, p. 261).*

*The medical establishment in mid-nineteenth-century Dundee was made up of a diverse group of practitioners, in terms of education, qualification and experience, much of which still reflected the pathways and practices of the late eighteenth century. Dominated by leading medical families and intricate social networks, the medical community increasingly established itself in a distinct quarter within the city, and entrenched itself in the wider community through public appointments and civic office. This paper will explore the landscape of medical practice in this local 'niche', examining the ways in which the resident medical men created themselves both as individual practitioners with status and influence – the newly emerging 'general practitioners' – and as a distinct and respected professional community.*

**Keywords:** *Medical practice, general practitioners, nineteenth century, local, Scotland*

## Introduction

In 1872, the cream of the medical profession in Dundee gathered in the Royal British Hotel in Castle Street to honour one of its longest serving and 'most highly-esteemed' members. Having disposed of a sumptuous meal, followed by numerous toasts and speeches, the sixty-plus diners applauded and cheered as Matthew Nimmo was presented with a 'magnificent' silver salver, a bronze gilt clock and the grand sum of 800 sovereigns 'as an expression of their high sense of his professional service and private worth' (*Dundee Courier*, 1872a). Matthew Nimmo (1801-1884) had entered the medical profession at the age of only fourteen years, in apprenticeship to his uncle, Patrick Nimmo (1776-1855). A local newspaper, reporting on the event, summed up the significance of the occasion:

If any professional man has a right to retire from his profession long before he has been engaged in it for fifty years, it is the medical man. But, at the same time, when a medical man reaches his jubilee in his professional career, a completeness and roundness are given to it that it would not otherwise possess [...] none but the man who has worked on for such a period of years in such a profession, through encouragement and discouragement, through summer's heat and winter's cold, by night and by day, can in any worthy measure realise the toil and trouble through which he has passed (*Dundee Courier*, 1872b).

Matthew's death at the age of eighty-three would follow a long, successful and varied career as a doctor. He actively engaged in public life in a number of ways, earning him the respect of the community as a whole. His funeral at St Paul's Free Church in Dundee, where he had been 'long an esteemed office bearer', was attended

by ‘the greater number of the medical faculty of the town’, echoing the happier occasion and presentation of twelve years earlier (*Dundee Courier*, 1884). He had pursued, down to the last, a well-rounded and complete medical career, the diversity of which characterised this generation of doctor (Digby, 1999, p. 264). In the accolades and tributes, the consumption of great feasts and the presentation of trophies, the members of the medical establishment celebrated their position in Dundee society. They also consolidated their professional status, a status which had had to be earned and needed to be safeguarded. During the course of their careers, these doctors witnessed radical changes in the profession, to the systems of medical education, and to the daily business of being a doctor.

Matthew Nimmo and his contemporaries were among what might be regarded as the first ‘general practitioners’, although early in their careers the term was not in general public use and indeed was infrequently used within the medical profession itself. By the middle of the nineteenth century, the ‘general practitioner’ was responsible for the ‘ordinary medical care for much of the population’ (Digby, 1999, p. 2). Competing for ‘professional survival’ in a new and evolving climate, early general practitioners needed to cultivate and exploit ‘community niches’ to gain professional recognition, manipulating and infiltrating local organisations and societies (Digby, 1999, p. 261).

This paper will examine the landscape of medical practice in one such ‘niche’, the rapidly industrialising city of Dundee in which Matthew Nimmo practiced, during the mid-nineteenth century, and will consider how he and other general practitioners created and maintained professional personae, both as individuals and as members of a medical community. Three main strands will be examined; the backgrounds and qualifications of mid-nineteenth century medical practitioners, considering how far their education and experiences reflected those of eighteenth century practitioners and were a re-creation of their roles; the establishment of an enclave of medical practitioners within the city, and the creation of a respectable, genteel medical community; and the participation of ordinary medical men in a professional network, examining this in terms of Digby’s understanding of the exploitation of ‘community niches’ in order to create and maintain a robust model for professional survival.

### **Becoming a Doctor: Education and Experience**

The general practitioner as we might recognise the term was a creation of the nineteenth century, evolving into the family and community doctor from the ‘surgeon-apothecary and man midwife of the eighteenth century’ (Loudon, 1986, pp. 1-2). Previous uses of ‘general practice’ had referred to just that – ‘usual’, or ‘broadly based’ medical practice (Loudon, 1986, p. 1). Changes in ideas about the situation of disease and its identifiable markers in the body itself moved medical care from the remote diagnosis of the physician into the realms of hands-on medicine, allowing medical men to become ‘the licenced examiners of strangers’ (Nicolson,

2017). Innovation and improvements in medicine brought effective treatments, and an increasing awareness of the practicalities of public health, opening up the possibility that a doctor's efforts could actually do some good. Furthermore, the nature of day-to-day ailments and the illnesses and diseases encountered in the community, generally medical rather than surgical, made the blurring of boundaries between 'supposedly distinct' groups necessary for economic survival (Loudon, 1983, p. 14).

The 'general practitioner' came into being as a medical man and 'general practice' as a branch of medicine, facilitated by these new ideas in medicine and changing social structures. At the same time, the general practitioner was a re-creation of the ideas and practices of previous practical medical care, of those who undertook the day-to-day business of primary care. In essence, emerging from an unspecific mix of medical men, with different qualifications, training and experiences, the general practitioner was the self-creation of a body of like-minded practitioners, and came into being in the nineteenth century as a result of the existence of 'a substantial number of medical men, joined by a sense of corporate identity, who adopted and wished to be known by the title of "general practitioner"' (Digby, 1999, p. 1; Loudon, 1983, p. 13). This was not to be an easy path. While the cost of medical education was high, the market was fed by aspiring middle class families and 'an abundance of young men who had set their hearts on a career in medicine', producing a surfeit of doctors and an 'overcrowded profession' (Loudon, 1983, p. 16).

Providers of eighteenth century healthcare had been a mixed and varied group – tradesmen and shopkeepers, itinerant entrepreneurs and confidence tricksters, quacks and 'quasi-irregulars', alongside trained practitioners of one form or another; it was not easy to differentiate between 'orthodox' and 'unorthodox' (Loudon, 1986, pp. 11-13). As Loudon notes, 'at each end of the spectrum the two are easily distinguished; in the centre, they merge imperceptibly' (Loudon, 1986, p. 13). Even among 'regular practitioners', boundaries would fluctuate, particularly between urban and rural areas, leaving the various titles open to interpretation, and often depending more on what practitioners would or would not do rather than their education and training.

Some called themselves 'physician' but had no degree; others who were fully fledged physicians in the provinces sometimes dispensed medicines, although the refusal to dispense was one of the features which typically distinguished the physician from the apothecary and the surgeon-apothecary (Loudon, 1986, p. 24).

Of the three main types of medical practitioners in the eighteenth century, the physicians were the highest ranking, and were usually in possession of a degree, though not necessarily a university education. It was possible to acquire a medical degree 'with minimal effort' through some kind of study abroad, or 'for a modest fee and the recommendation of two colleagues'; though despite the financial basis and the apparent lack of undertaking any kind of medical curriculum, this transaction did at least reflect an assessment of the recipient's previous work and experience and 'proven clinical ability' (Loudon, 2000, p. 1589; Loudon, 1986, p. 38). Physicians, in the true sense of the word, did not physically examine their patients, but offered an opinion

and diagnosis based on observation and the responses of the patient (Loudon, 1986, pp. 19-20). The patient's description of his illness, and not the body itself, was therefore 'the pivotal point in the diagnostic process' (Nicolson, 2017). The more practical, manual nature of the surgeons' work placed them further down the scale, though their status rose in the eighteenth-century due to advances in the understanding of anatomy (Loudon, 1986, p. 24). A third group, the apothecaries, dispensed medicines and were not supposed to treat patients at all, though many did, and they were subject to inspection by the physicians (Loudon, 1986, p. 21). The physicians' 'elite status' was underlined by their inherent lack of contact with their patients, emphasising the superiority of the mind over 'manual skills' (Nicolson, 2017). Understandings and practices of these definitions cast their shadow into the nineteenth century.

Such distinctions may have had less relevance in Scotland than elsewhere in Britain and Europe, as the boundaries between 'physic' and 'surgery' were culturally less defined (Lawrence, 2006, p. 212). Nicolson has argued that, in Scotland, the historical influence of a strong research culture had the effect of reducing the 'social and professional distance' between physicians and surgeons, citing many instances where prominent members of the different branches of medicine in Scotland had worked together without any regard for any loss of esteem or status in doing so, resulting in a quite distinctive climate in Scottish medicine and healthcare (Nicolson, 2017).

Medical education in Britain during the early nineteenth century was still largely unstructured, with practitioners able to gain their qualifications from a number of sources (Dingwall, 2003, p. 269; Lawrence, 2006, p. 215). Although in Britain the move towards doctors being educated primarily through a university education and medical curriculum seems to have begun in Scotland, the usual procedure in the first half of the nineteenth century remained a collection of routes followed by licensing by one of the medical corporations (Lawrence, 2006, pp. 212-213). Matthew Nimmo had followed a not uncommon path in entering into an apprenticeship at the young age of fourteen. During the eighteenth century, and to some extent into the nineteenth, the most commonly followed route for young men pursuing a medical career was an apprenticeship to a surgeon followed by collegiate licencing. A university degree was not a licence to practice, and, although more common in Scotland at this time, did not become a standard element of medical education until much later (Lawrence, 2006, p. 213).

An apprenticeship could be a rigorous and demanding start to a medical career, with boys as young as fourteen placed entirely in the hands of a master who acted 'in loco parentis in guiding his young charges' (Bonner, 2000, p. 44). Alexander Bell (1776-1855), a Dundee physician of forty-three years practice between 1807 and 1850, was noted as having had 'numerous pupils and apprentices' to whom he 'endeared himself no less by the kind interest which he manifested in their professional education and prospects, than by the excellent example which he set before them of what a professional man should be' (Norrie, 1873, pp. 135-136). An apprenticeship to a respected relative, a father or an uncle was also common and an attractive option for the sons and nephews of medical men. For the apprentice, this was a 'painless entry to a prosperous occupation';

for the mentor, this was an economical way to add to the practice, though it often led to the formation of ‘medical dynasties’, with successive generations and multiple members of the same generation entering the profession (Loudon, 1986, p. 29; p. 34). The Nimmo family’s influence was significant, and perhaps began with Matthew’s grandfather, Patrick Nimmo (died 1836), who is noted in 1788 in the Dundee Lockit Book, the Burgess Roll of Dundee, as a ‘Barber’ (FDCAb). It might have extended further, had it not been for the untimely death in 1845 of Matthew’s cousin (also Patrick), a surgeon, from ‘disease of the heart and lungs’, at the age of 35 (FDCAa).

Following his apprenticeship, Matthew Nimmo studied in Edinburgh at the Royal College of Surgeons to qualify as L.R.C.S. (Licentiate of the Royal College of Surgeons) in 1820. The educational background of doctors practising in Dundee during the mid-period of the nineteenth century reflected a range of qualifications, and no clear path to medical practice. The Dundee Directory for 1853-54 lists thirty-four men as ‘medical practitioners’ for the Dundee area, and of those, twenty-two are listed in the Medical Directories as ‘LRCS Edin’ and one as ‘MRCSE’ (Member of the Royal College of Surgeons, England); ten of those are listed as ‘LRCS’ only. This last category tended to apply to the practitioners who had been practicing medicine since early in the century, though some of these acquired a degree at a later date; for example, James Maxwell (1795-1863), who was awarded his diploma in 1815 from Edinburgh, gained his MD (Doctor of Medicine) from the University of Edinburgh in 1839. Of those practitioners with medical degrees, nine were awarded at Edinburgh University, six by St Andrews, and one each by Aberdeen and Glasgow. Five doctors held a degree but cannot be identified as having been awarded a licentiate – these again were the longest practicing doctors (*Dundee Directory 1853-54; British Medical Directory 1853; The Medical Directory for Scotland 1855; The Medical Directory and General Medical Register for Scotland 1859*).

The dominance of the University of Edinburgh in this group reflects the position of Edinburgh Medical School as one of the most prestigious in the world during the nineteenth century, though Glasgow would soon increase in influence, with the expansion of the city itself. It is noticeable that all but one of the Edinburgh graduates gained their degrees during the 1820s and 1830s. St Andrews, on the other hand, was ‘a byword for worthless degrees during the Enlightenment’ and, while standards rose in the late Victorian era, it was not a major centre (Lawrence, 2006, p. 213). The relatively high number of St Andrews graduates in this group is probably a reflection of its proximity to the Dundee area. All but one of the St Andrews alumni graduated in the 1840s, a point at which this university was beginning to adopt ‘more modern characteristics’, having had no actual medical faculty and a reputation for selling degrees, though it was not until the foundation in 1881 of University College in Dundee that St Andrews was able to claim anything like a ‘full medical school’ (Lawrence, 2006, pp. 216-217).

A further component of medical education was often a period of some kind of practical service in which the young doctor would have the opportunity to try out and refine his medical skills. Following completion of more formal educational studies, of whatever form, a short career at sea, or in the military, was a common start

to a professional career and could provide many opportunities for a young physician to try out and improve their skills, and enjoy a significant financial boost. Matthew Nimmo served as a surgeon aboard the East India Company vessel the *Mellish*, sailing to Madras and Calcutta, before returning to Dundee to set up practice (*Dundee Courier*, 1872a). Such a position offered a ‘lucrative source of medical employment’, as did the opportunities offered by slave ships in the eighteenth century and emigrant vessels in the nineteenth (Dingwall, 2003, p. 194). Prior to taking up practice in Dundee, Alexander Bell served in Ireland during the rebellion of 1798 with the 1<sup>st</sup> Regiment of Dundee Volunteers, as surgeon, and at first as lieutenant and rising to the rank of captain (Norrie, 1873, p. 135). James A. Cowper (1826-1866), served in the Crimean War as first surgeon to the 7<sup>th</sup> Regiment of the Turkish Contingent (Norrie, 1873, pp. 263-264). David Greig (1831-1890) made the acquaintance of Florence Nightingale during his time in the Crimea. He had trained under James Young Simpson at Edinburgh, who apparently urged him to take with him to war a supply of chloroform in the hope that he could ‘show them how to use it’ and urged Greig to write to him about not only the wounds but the diseases he encountered. Such experiences offered the chance of excitement and adventure and were regarded as providing young doctors with a good foundation on which to build their medical careers. David Greig declared that his intention in joining the army was ‘to get surgical practice, to see the world, to get the *éclat* of being at the war, and to get a year’s recreation before settling into practice’ (Kinnear, 1954, p. 144).

By the middle of the nineteenth century, the apprenticeship system was dying out, though it remained common outwith large towns, and a move towards medical reform was underway, a ‘bitter struggle’ driven largely by a desire among those who considered themselves to be legitimate medical practitioners to distinguish themselves from the ‘quacks’ or ‘irregulars’ (Lawrence, 2006, p. 215; Loudon, 1986, pp. 2-3). The 1858 Medical Act represented a move to standardise the various routes of entry to the medical profession on a national level, in order to ensure, on the basis of ‘examination as proof of knowledge and competence’, that all entry routes were ‘equally worthy’ (Dingwall, 2010, p. 269). While not universally welcomed by the Scottish colleges, who saw the Act and subsequent proposed amendments as ‘a threat to their recognition as licensing bodies’, the Act did set the profession on a route to a regulated curriculum and national standardisation, introducing a requirement for registration, for which a recognised qualification was necessary (Dingwall, 2010, pp. 269-270; Lawrence, 2006, p. 215). The intention, if not the effect, was to even out the anomalies present in the landscape of medical education and establish professional credibility. The doctors practicing in Dundee in the mid nineteenth century were undoubtedly a diverse group reflecting the practices of the not-so-distant past, in terms of education, qualifications and experience, but there was demonstrably an influential and active group of practitioners keen to demonstrate some level of medical knowledge and able to provide evidence of having received instruction and undertaken assessment, and to advertise themselves according to a defined and organised public identity.

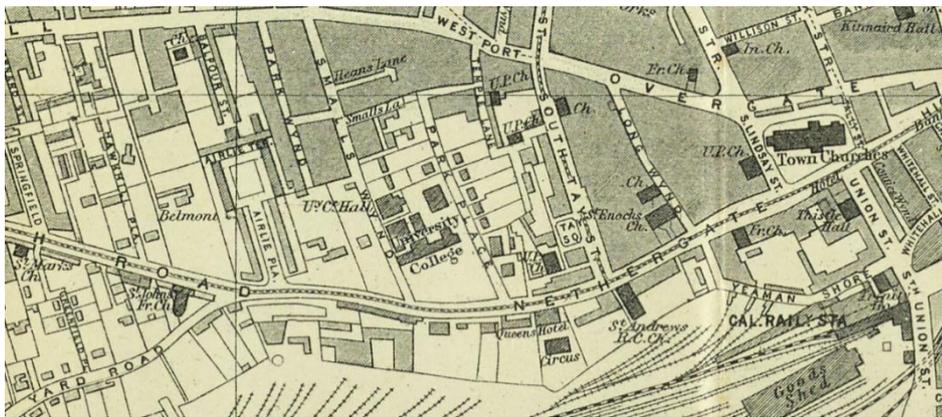
## Doctors in Practice: The Doctor's Place

Alexander Bell, noted as being 'a surgeon and general practitioner, and consulting physician', ran an 'extensive and lucrative' medical practice in Dundee from his residence at 164 Nethergate (Norrie, 1873, pp. 135-136). Very few of the doctors listed in the 1853-1854 Post Office Directory are noted as having a home address as well as a professional one. Digby, in her study of general practitioners between 1850 and 1948, noted that the doctor's house was frequently both his home and his surgery, and acted as the 'lynch pin between public and private', bringing the doctor's family into his professional life (Digby, 1999, p.278). Portraits of Bell and his wife Anne, whom he married in 1803 and who predeceased him by only two years, are housed among the Tayside Medical History Museum collection. The paintings were presented by the Bell family to Dundee Royal Infirmary, where Bell had officiated as a surgeon, but the inclusion of Anne's portrait is a fitting tribute to her own role ([www.Dundee.ac.uk/medical\\_portraits](http://www.Dundee.ac.uk/medical_portraits)). As the wife of a doctor, she would have had a significant contribution to make to the success of the practice; she would have been a valuable 'professional asset', ensuring the smooth running of his household, and also performing more specific tasks such as account keeping, collecting outstanding fees, carrying out correspondence and generally keeping the practice running smoothly. A well-connected, respectable and pious doctor's wife could help raise his social profile and greatly enhance his professional reputation (Digby, 1999, pp. 275-276).

The Bells' residence was a two-storey villa built around 1785, offering respectable accommodation, one of 'a handful of self-contained dwellings' housing the city's more 'affluent citizens' in the commercial quarter of the city (Historic Environment Scotland; Whatley, 1993, p. 111). Of the thirty-four medical practitioners noted in the 1853-54 Dundee Post Office Directory list, no less than twenty-one are listed as residing or practising in the Nethergate or a closely neighbouring address – Tay Street, South Tay Street, Perth Road and Victoria Square. Matthew Nimmo and his uncle Patrick Nimmo occupied properties next door to each other at 17 and 15 South Tay Street. Other medical practitioners had their addresses in the Seagate, Murraygate and Wellgate areas, with some doctors residing in King Street, presumably conveniently near to the site of the original Dundee Royal Infirmary (Whatley, 1993, p. 107). The concentration of doctors in the Nethergate area and adjacent streets was quite marked, and increased as the century progressed. By the mid-1880s and towards the end of the century, the most popular address for physicians had become South Tay Street, and the medical enclave had extended to include nearby Airlie Place, a street of elegant terraced houses built around 1846, and to some extent the parallel terrace at Springfield (British listed buildings; *Dundee Directory 1885-86; Dundee Directory 1899-1900*).

There may have been a collective memory of the area as associated with healing and medical care – the Nethergate had been the site of the Town's Hospital, an impressive 17<sup>th</sup> century construction which had once dominated the entrance to the city through the Nethergate Port (McKean et al., 2008). This building, fully

demolished by 1830, had latterly been used to house French prisoners of war, and whatever function it had ever had in the business of healing was some distance in the past by the time the medical practitioners of Dundee had begun to establish a presence in the area. The influx of doctors, moreover, seems to have been a development of the nineteenth century. In the late eighteenth century, the Nethergate had been populated with a diversity of occupations – hammermen, coopers, wrights and carpenters, maltmen and merchants, shipmasters, and others including a private teacher and ‘chaise and horse letter’ (*Dundee Register*, 1783). The area did have the advantage of being close to the city centre, and to business, communication and transport links, and it would have presented a good position in which doctors could live and work. It may also have been indicative of a move by the members of the profession to display their respectability and standing.



Plan of Dundee to accompany directory. 1889-90 [Dundee: James P. Mathew & Co., 1889 to 1890]. Detail showing the Nethergate, with Springfield and Airlie Place to the left of the plan, and South Tay Street (leading to Tay Square) leading north from the Nethergate just right of the centre. Reproduced with the permission of the National Library of Scotland: <https://maps.nls.uk/index.html>

Nethergate, one of the streets connecting the city to the main route from Perth, was a crowded mixture of businesses and houses. Until the mid-nineteenth century, it was largely undeveloped and remained a densely populated street characterised by ‘narrows’, points where the width of the street was as little as six feet (McKean, 2011, p. 13). A small number of mansions and villas, including that of Provost Riddoch, built in 1790, had begun to pepper the area (Whatley, 1993, p. 100). Such developments echoed a continuing trend in city landscapes in Scotland which allowed urban gentry to reside ‘in the relative seclusion of new streets and squares’ while allowing their gentility and refinement a certain visibility (Harris and McKean, 2014, p. 304). In this, Dundee had tended to lag behind other Scottish cities. Plans to improve the city centre and develop a ‘new town’ in Dundee were long hampered and delayed by local politics and lack of strategic planning on behalf of the town council. The building of new streets in the early and mid-nineteenth century such as Tay Street, Tay Square, Airlie Place and Springfield did form part of these plans, and the resulting terraces provided elegant, respectable accommodation (McKean, 2001, pp. 26-27).

In comparison with other Scottish cities, the professional sector in Dundee played a lesser role within the overall employment structure, and medicine and dentistry made up only a small percentage within that landscape (Morris and Rodger, 1993). Nevertheless, the members of the medical profession sought to make

their mark in local society. They had not enjoyed the same social standing as law or the Church, and sought to claim ‘a gentlemanly status’ through being seen to enjoy ‘the trappings of gentility’ and the conspicuous ownership, or at least occupation, of desirable property, with carriages, and the employment of servants (Digby, 1999, p. 41). The Bell household in 1851 boasted three live-in servants (1851 census). Gradually the numbers of doctors residing in the Nethergate area increased until they had formed an enclave of the most active and connected of their profession, inhabiting the fine Regency-style terraced housing with Doric porticoes – though they remained closer to the emanations of local industry than those who had chosen to join the ‘middle class exodus’ of the 1830s in favour of suburbs like Newtyle and Broughty Ferry (Whatley, 1993, p. 111).

### **The Name of the Doctor: Public Profiles**

The public profile of the doctor was key in establishing the status of the profession and its members. In order to enhance their reputations, medical practitioners, particularly in town settings, employed a range of ‘opportunistic strategies’ which often involved as much participation in charities and community organisations as possible, and included both medical and non-medical appointments. As Digby notes:

Especially during the Victorian and Edwardian eras general practitioners showed enterprise in developing the potential of their local environment by seeking out medically related appointments of varied kinds. [...] To establish a reputation, and to foster the trust of local people through face-to-face contact in a range of activities was vital to professional success (Digby, 1999, p. 261).

Throughout his long career, Matthew Nimmo combined his duties as a doctor with a number of appointments, and maintained a strong public profile. In addition to his medical appointments, he served on the bench of the Court of the Justice of the Peace, was involved as a director of the lunatic asylum, and took an active interest in public health. In 1853, he protested at the ‘filthy and noxious state’ of an area of land near Trades Lane which, he claimed, in a letter penned to the *Dundee Courier*, was responsible for ‘emanations’ which were ‘destructive of the health and comfort of the inhabitants of Dundee’ and ‘a continued source of disease (*Dundee Courier*, 1853). In 1876, he signed a petition in support of the removal of the city’s ‘time-gun’ from the vicinity of the Infirmary, on account of the distress it was apt to cause to severe and vulnerable cases (*Dundee Courier*, 1896).

Nineteenth-century Dundee was indeed richly endowed with opportunities for suitably prominent public medical appointments. William Lockhart Gibson (1811-1876) served as physician to The Home, an ‘institution for the reclamation of women who [had] lapsed from the paths of virtue’, founded by Lady Jane Ogilvie in 1848 (Norrie, 1873, p. 199). Robert Cocks (1812-1875) was ordinary director and surgeon to the Eye Institution in the Murraygate, and James Arrott (1808-1883) was physician to the Institution for Diseases of the Chest. There were also opportunities for physicians in civic services and organisations. Alexander Webster (1799-1863), as well as being physician to the Royal Infirmary, was also Medical Officer for Dundee Police Establishment. William Crichton Saunders (1809-1881) and William Monro (1829-1902) were both Certifying Surgeons under

the Factory Act. Robert Cocks, William Lockhart Gibson, Robert Langlands (1820-1865), John Lothian (1813-1859) and David Lyell (1807-1881) all served as medical referees to various life insurance companies, positions which were presumably more financially lucrative than appointments with charitable organisations (*British Medical Directory 1853; Dundee Directory 1853-1854*). Non-medical appointments were also useful in gaining or maintaining a 'high profile' in the community, which in turn could lead to opportunities for effective social networking and the potential to attract more 'affluent' clients (Digby, 1999, p. 264). John Crichton (1772-1860) was elected a Magistrate of Dundee, though he himself 'never troubled himself much about politics, and least of all about burgh politics' (Norrie, 1873, p. 183).

Professional reputations could also be forged, on a local and national level, through publication in the thriving numbers of medical journals which had begun to proliferate during this period. John Crichton wrote and published a number of papers in the *Edinburgh Medical and Surgical Journal* on his special subject lithotomy, but also offered observations on hydrophobia a case of caesarean section and an account of the intriguingly named 'Angus-shire leaping ague', a condition apparently prevalent among the marshy lands of Angus (*British Medical Directory 1853; Crichton, 1829; Warden, 1895, p. 178; 206*). James Arrott, in a contribution to the *Scottish and North of England Gazette*, added to the discussion on the 'epidemic fever of 1843' with a description of the characteristics of an outbreak in Dundee and similarities with yellow fever observed in the West Indies (Smith, 1844, p. 299; 301). Matthew Nimmo was a contributor to the *Edinburgh Monthly Journal of Medical Science*, including the publication of an article entitled 'Case of Caesarian section' (*British Medical Directory for England, Scotland and Wales 1853*). George Paton (b 1811) of Dundee was among a number of physicians, drawn from the length and breadth of Scotland, England and Ireland, who contributed to a report by James Young Simpson which was published in the *Monthly Journal of Medical Science* on the progress of anaesthetic midwifery. Mr Paton reported positively on the successful use of chloroform in 'upwards of fifty cases' but noted public antipathy towards its use following the deaths of two ladies from puerperal fever, as the public mind attributed their deaths to the use of 'the new agent' (Simpson, 1848, p.234-235).

On a more local level, Dundee doctors circulated and discussed their ideas through a number of medical organisations. The formation of such organisations was in part a reaction to the lack of a cohesive or 'collective body' to represent the interests of general medical practitioners (Loudon, 1983, p. 16). The Forfarshire Medical Association was formed in 1858 for the 'cultivation and promotion of medical science and of good fellowship'. The first meeting took place at the British Hotel on 23<sup>rd</sup> December 1858 (thereafter the committee met at 140 Nethergate, the residence of David Greig). Annual meetings of the whole association were held in hotels around Dundee, Montrose, Brechin and Arbroath, and were accompanied by a dinner and the presentation and discussion of papers by its members (UoDA, MS 46/1/1-4). The association also incorporated the Circulating Medical Book Society and the Montrose Medical Society. There were other organisations active in the area during the nineteenth century, such as the Dundee Medical Society, formed in 1864, the Dundee

Clinical Club and a Dundee branch of the British Medical Association, although the latter two did not come into being until 1893 and 1894 respectively.

These activities were all over and above the duties which might be expected of a family doctor, and demonstrate a personal commitment to making the most of opportunities. Even by the middle of the century, Dundee doctors can be seen to have actively embraced the use of opportunistic strategies to further their careers and reputations. They offered their services not only for the benefit of the community, but for the benefit of their own personal professional reputations.

## **Conclusion**

The Dundee medical establishment of the mid-nineteenth century comprised a relatively diverse group of practitioners, in terms of education, qualification and experience, many of whom reflected the pathways and practices of the late eighteenth century. They represented a close community, both vying for professional survival and co-operating in the development of their new social and professional standing, very much in accordance with Anne Digby's concept of the 'community niche' (Digby, 1999, p.261). Dominated by leading medical families and intricate social networks, the medical community increasingly established itself in a distinct quarter within the city, entrenching itself in the community through public appointments and places of influence. They referred to each other as 'medical friends' and 'brethren' – social niceties or professional etiquette, perhaps, but these habits, along with their rituals and celebrations, signified, at least outwardly, this supportive and cohesive community.

While Dundee's medical practitioners sought to establish themselves as professionals, gentlemen and leaders of the community, they also reached out to the medical establishment beyond the area through publication and active participation in the wider discussion of medicine and medical practice. They were instrumental in creating a new kind of doctor, and a new specialty, though they would remain for many years an 'anomalous' group with no professional body to look after their interests – attempts as early as the 1840s to establish a College of General Practitioners were blocked by the 'petty objections' of the Colleges of Physicians and Surgeons (Bonner, 2000, pp. 183-184; Loudon, 1983, p. 17). In fact, it was not until 1952 that the College of General Practitioners was legally constituted, gaining a Royal Charter as late as 1972 (Simon, 2009, p. 7). The role of the general practitioner today remains crucial to the functioning of health care provision in Britain today, as the first point of contact and the gateway to specialist services (Dingwall, 2003, p. 212).

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