

## “Strike out Boldly for the Prizes that are Available to You”: Medical Emigration from Ireland 1860–1905

GRETA JONES\*

Throughout the late nineteenth and twentieth century there was a continuous flow of doctors emigrating from Ireland.<sup>1</sup> Governments and medical schools in Ireland were aware of this phenomenon, but most calculations of the extent of medical emigration were largely impressionistic. The *Report of the Commission on Higher Education* in the Republic of Ireland in 1967 commented:

Medical school authorities informed us that it was particularly difficult to place a figure on the rate of emigration of Irish doctors. A survey of the pattern of emigration over a long period involving the tracing of many individuals would be required to obtain accurate information and, in particular, to isolate the number of doctors who emigrate permanently. This we have not had the opportunity of doing.<sup>2</sup>

In order to gain a more accurate insight, the current study surveyed doctor emigration from Ireland between 1860 and 1960. The cohorts were selected from five leading medical schools in Ireland.<sup>3</sup> Beginning in 1860, the survey looked at the cohorts at five-year intervals until 1960. It thus covered 4,265 graduates, who were examined for their place of residence in the *Medical Register* and the *Medical Directory* ten years after graduation. Smaller studies were done five, fifteen and twenty years after graduation to establish the accuracy of the ten-year cut off point. The figures obtained suggest that for the period 1860–1960 about 41 per cent of the cohorts examined were practising

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\*Greta Jones, PhD, University of Ulster, Centre for the History of Medicine in Ireland, Shore Road, Newtownabbey, County Antrim BT37 0QB, UK; e-mail: GJ.Jones@ulster.ac.uk

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<sup>1</sup> Ireland experienced general emigration after 1850 leading to a decline in her population over much of the nineteenth and twentieth century. Medical emigration was, however, unique in certain respects. Unlike most emigration, it was the professionally trained who left. The peak of medical emigration and its destinations also show patterns quite distinct from that of the emigrant population as a whole.

<sup>2</sup> *Report of the Commission on Higher Education 1960–67*, 2 vols, Dublin, Stationary Office, 1968, vol. 1, p. 246. The commissioners suggested that in the preceding decade emigration was around 25 per cent of all medical graduates from the Republic.

<sup>3</sup> The context in which these schools operated changed over the years. Students at the Queen’s Colleges at Cork, Galway and Belfast were until 1879 graduates of Queen’s University of Ireland. The Colleges and the Catholic Medical School were brought together in the Royal University of Ireland in 1879, whose first graduates appeared from 1883. Then, following a major reorganization of Irish higher education in 1908, Cork, Galway, and the Catholic University Medical School became the National University of Ireland, and Queen’s College, Belfast, became the Queen’s University of Belfast. Schools, however, continued to produce their own graduation lists in their annual calendars and these have been used for this study.

outside Ireland after ten years, around 44 per cent were in Ireland, and 15 per cent were unaccounted for.

However, broken down by period, patterns of emigration change. Over the hundred years examined, medical emigration, whilst still a significant part of Irish experience, drops. Other changes occur in terms of destination and motivation. This article, therefore, concentrates upon the nature of medical emigration between 1860 and 1905 using the 1905 graduates as the last cohort. This was done because the following cohort of 1910 started their careers in medicine around the time of the National Insurance Act of 1911 and, shortly after, the 1914–18 war. These two events significantly changed the situation for the emigrant doctor and suggest that the cohorts of 1910 and 1915 need separate treatment.<sup>4</sup>

The five major medical schools whose cohorts were studied were the Queen's Colleges of Galway, Cork and Belfast founded in 1845, the University of Dublin (Trinity College, TCD) and the Royal College of Surgeons in Ireland (RCSI).<sup>5</sup> These, together with the Apothecaries' Hall, Dublin, whose graduation lists were not available at the time of writing, were the main licensing schools in Ireland in the late nineteenth century. The Royal College of Physicians of Ireland produced licentiates (LRCPI).<sup>6</sup> However, it was an examining body only, traditionally associated with the School of Physic in Trinity College, Dublin. It opened its examinations to the students of the Catholic Medical School (1854) helping to ensure that school's survival. Until the Medical Act of 1886 the standard degree in the graduation lists was MD. After 1886 it became the "holy trinity" of MB, BCh, BAO (medicine, surgery and obstetrics). The Royal College of Surgeons educated students and licensed them (LRCSI). After the Medical Act of 1886 created a conjoint examining board with the King and Queen's College of Physicians of Ireland, the graduates of the RCS were both LRCSI and, until 1889, LKQCP. By 1900 the Irish degrees recognized by the General Medical Council (GMC) were LAH, MB, BCh, BAO, LRCSI and LRCPI.

Medical school and licensing body were not always the same. The Catholic Medical School in 1865 had 20 first year students of whom 17 graduated from the Royal College of Surgeons (LRCSI), two from the Apothecaries' Hall, Dublin (LAH), and one via the exams of the King and Queen's College of Physicians of Ireland (LKQCP).<sup>7</sup> The major

<sup>4</sup>The National Insurance Act of 1911 allowed for medical treatment for insured persons in certain working-class trades and occupations and, therefore, represented a significant expansion of state funded medical care available outside the Poor Law system. The significance was most felt in working-class districts which had a proportion of insured persons. This meant the social and economic geography of general practice changed.

<sup>5</sup>For a history of the various schools, see J D H Widdess, *A history of the Royal College of Physicians of Ireland 1654–1963*, Edinburgh, E and S Livingstone, 1963; Charles A Cameron, *History of the Royal College of Surgeons in Ireland*, Dublin, Fannin, 1916 (1st ed. 1886); Peter Froggatt and Barry Bridges, *The Belfast Medical School 1835–1985*, Belfast, *Ulster Medical Journal*, 1986; John A Murphy, *The*

*College. A history of Queen/University College Cork, 1845–1995*, Cork University Press, 1995; Donal McCartney, *UCD: A national idea: the history of University College Dublin*, Dublin, Gill and Macmillan 1999; F O C Meenan, *Cecilia Street; the Catholic University School of Medicine 1855–1931*, Dublin, Gill and Macmillan 1987; Tom Dunne (ed.), *The National University of Ireland 1908–2008*, University College Dublin Press, 2008.

<sup>6</sup>Before 1889, the College was named the "King and Queen's College of Physicians of Ireland" with licentiates being designated LKQCP.

<sup>7</sup>Calculated from 209 entries for place of study for first year registrants in the *Medical and Dental Student's Register*, published annually by the General Medical Council, 1865.

## Medical Emigration from Ireland 1860–1905

Table 1  
Destination of medical graduates from Ireland.  
Percentages. Raw numbers in brackets

Years	Ireland	Not in <i>Medical Register</i>	Outside Ireland	
1860–95	32% (244)	15% (112)	53% (398)	754
1900–15	37% (228)	14% (85)	49% (305)	618
1920–40	47% (660)	14% (200)	39% (540)	1400
1945–60	51% (750)	16% (235)	33% (489)	1474
Total 1860–1960	44% (1882)	15% (632)	41% (1732)	4246

Source: *Medical Register of the United Kingdom*, for the relevant years.

private schools—Stevens, Ledwich and Carmichael—in the same year had a total between them of 56 registered students, of whom 26 eventually took their exams at the Royal College of Surgeons, 6 at the School of Physic (Trinity College's medical school), one at the Queen's College, Belfast, and 20 at the Apothecaries' Hall.<sup>8</sup> The students of the Catholic Medical School continued to graduate LRCSI and LRCPI, although after the Catholic school became the medical school of University College, Dublin, in 1909 this changed.<sup>9</sup>

The graduation lists of these five schools provide, therefore, a pretty comprehensive picture of the outcome of medical education in Ireland in this period. They include a small proportion who were already licensed to practise largely via the Apothecaries' Hall or who, particularly after the medical reforms of the 1880s, attempted to upgrade their original qualifications, but the majority were newly minted graduates.

There are, of course, complexities in the picture of emigration presented in Table 1. By excluding medical students, it underestimates the amount of actual emigration. It was still common in the late nineteenth century for Irishmen to seek an education outside Ireland particularly in Scottish universities; more rarely in provincial English schools, London, Oxford or Cambridge. Anne Crowther and Marguerite Dupree's work on the cohort of graduates from the medical schools of Edinburgh and Glasgow suggests that 6 per cent of those who began the study of medicine in Glasgow in 1871 and 4 per cent in Edinburgh were Irish born. This was about the same for Welsh students but considerably less than the proportion of English students—12 per cent in Glasgow and 32 per cent in Edinburgh.<sup>10</sup> However, only a small proportion of Irish graduates returned to Ireland.<sup>11</sup> Crowther and Dupree state that 56 of their cohort were born in Ireland but only 12 practised there.<sup>12</sup>

Similarly Laura Kelly's work examines the destinations of Irish graduates trained in Glasgow University medical school between 1859 and 1900 five years after graduating.

<sup>8</sup> *Ibid.*, 1865.

<sup>9</sup> At this point UCD medical schools begin to produce their own graduation lists. A few Catholic University students are designated graduates of the Royal University from 1883, but most appear on the RCS lists as well.

<sup>10</sup> M Anne Crowther and Marguerite W Dupree, *Medical lives in the age of surgical revolution*, Cambridge University Press, 2007, Table 1.4, p. 23.

<sup>11</sup> Less than 1 per cent of the total cohort, *ibid.*, Tables 6.1, 6.2, p. 177.

<sup>12</sup> *Ibid.*, p. 253.

Her conclusion is that only one in three of the Irish-born medical graduates of Glasgow returned to practise in Ireland. Some whom she records as returning to Ireland within five years, may subsequently have joined the Irish doctors migrating within the ten year time span used in this study. But these would be untraceable by the criteria used here, which examines only graduates from Irish medical schools.<sup>13</sup> So this study, by excluding Irish men and women graduating from Scottish medical schools, underestimates the total amount of medical migration from Ireland. Additionally, figures for the “not ins” (meaning those whose names do not appear in the relevant *Medical Register*) remained remarkably consistent over time. But it cannot be assumed that some of these were not in fact practising overseas in regions where being on the British *Medical Register* was deemed irrelevant. However, in the majority of cases, death or change of profession accounts for most of those dropping off the register.

The bare figures from this study also underestimate the amount of peregrination that took place in the medical profession in the late nineteenth century. Settling down five or even ten years after graduation was not possible for every medical graduate. Some served several years as ship’s doctors on the Cunard or Pacific and Orient (P and O) shipping lines prior to setting up practice. Those who settled in Ireland or migrated to Britain often moved several times as assistants in practices before becoming established in a particular location. Though most were settled after ten years, this outcome cannot always be assumed.

An example of a highly mobile doctor is Archibald Montford, born in Carlow, who entered TCD medical school aged eighteen and graduated in 1875 with a silver medal for clinical medicine.<sup>14</sup> Montford, after attending the Rotunda for clinical training, studied at Bonn and Vienna. In the late 1870s he appears in Staffordshire at Brindley Ford as surgeon to the Coal and Iron Foundry at Biddulph and doctor to the Manchester Assurance Society. During 1881–2 he is in Kent, and in 1883–5 he is ship’s surgeon on the SS *Kepler*. Thereafter his address is “un-communicated” until he reappears back in Ireland at Tiny Park, Carlow, in 1890. By 1900 Montford has a Dublin address where he is still residing in 1910. But thereafter his address is again “un-communicated” until he finally drops out from the 1918 *Medical Directory*. Such a restless career is, however, unusual, and from supplementary studies done of longer periods, the ten year cut off on the whole provides a reasonable measure of eventual settlement.<sup>15</sup>

None the less, some graduates who after ten years are registered outside Ireland were in military or colonial service and eventually moved back. This can be seen by wills probated in Ireland from Irish addresses by doctors who spent their careers in India or other

<sup>13</sup> Laura Kelly, ‘Irish medical students at the University of Glasgow 1859–1900’, M.Litt thesis, University of Glasgow, 2007, pp. 61–2, Table 3.2. Over 100 students were examined.

<sup>14</sup> Information based on the *Medical Directory*. His father Henry was a doctor also; his main career was spent on the Isle of Man.

<sup>15</sup> 566 graduates were examined between 1860 and 1950 every five years as well as every ten years after graduation. Between five and ten years emigration outside Ireland increases. Around one in

four had moved between the five year and the ten year cut off date. 102 graduates between 1860 and 1890 were examined both ten years and twenty years after graduation. Between the ten and twenty year cut off point movement diminishes. Excluding an additional number who drop off the register, there was a 10 per cent movement out of Ireland and a 3 per cent inward movement, mainly returnees from army or Indian medical service. This leaves further migration out of Ireland of around 7 per cent.

parts of the British empire, and by entries in D G Crawford's *Roll of the Indian Medical Service* on place of death. The probated wills in Ireland include that of Robert Reid, who graduated in 1854 from the Queen's University of Ireland, obtaining the licentiatehip of the King and Queen's College of Physicians in 1865. He spent twenty-five years as a surgeon in the Bengal army and died in Ireland at Lisburn, County Antrim, on 26 March 1907. Reid drops out of the *Medical Directory* after 1893 and does not appear to have practised in Ireland. In Reid's case this may have been because of the significant fortune he had amassed. In addition to his RAMC pension, he left £21,017, much of it in securities, bonds and deposits in the Hong Kong and Shanghai Bank, and in Grindley's Bank.

For others in the military or colonial service, retirement might mean re-establishing themselves in private practice. Robert Taafe was born in 1851 and graduated in 1875 from TCD's medical school. Taafe joined the Indian Medical Service (IMS) in 1876 and spent ten years, including active service, on the North-West Frontier. On a ten-year analysis he slips into the category of outside Ireland. However, Taafe is recorded in Crawford as taking up medical practice in Kingstown, County Dublin, after his resignation from the IMS.

Thus there are all kinds of factors which make this sort of study an inexact science. The career of each individual is unique. However the period 1860–1905 produces a cohort of around 976, the majority of whom show relatively settled patterns of career progression. Two destinations in particular, a practice in England or service in the military or the colonies, stand out as the route taken by the majority of graduates practising outside Ireland. To sum up, around 53 per cent were practising outside Ireland after ten years.<sup>16</sup> The majority were in England.<sup>17</sup> Another substantial number served in the military or the colonies of the British empire, and emigrant destinations such as Australasia. A minority went elsewhere—China and the Far East, South America or Europe—but they often worked for British firms or for British communities and thus remained within the British sphere of influence.<sup>18</sup>

Crowther and Dupree's study shows even higher rates of dispersal. Ten years after graduation, 38 per cent of medical graduates from the two Scottish universities of Glasgow and Edinburgh were practising in Scotland, and around 60 per cent outside Scotland, mainly in other parts of the British Isles, particularly England. But their figures of migrants are boosted by the fact that Edinburgh recruited students much more widely from the British Isles, and many of her students, rather than emigrating, returned to their place of birth after their studies were completed.<sup>19</sup> If we take Glasgow alone, where the proportion of Scottish born students was higher than Edinburgh, 48.9 per cent of Glasgow's medical graduates remained in Scotland and around 54 per cent migrated, comparable to figures of Irish medical emigration overall in this period. Trinity College,

<sup>16</sup> Of the 976 graduates 1860–1905, 130 are “not in” the *Medical Register*, 316 are in Ireland, 530 outside Ireland.

<sup>17</sup> Between 1860 and 1905 only one graduate was traced to Scotland and three to Wales.

<sup>18</sup> See Crowther and Dupree, op. cit., note 10 above, pp. 320–24, on the movement of medical personnel to China ports, and Anne Digby's study of doctors emigrating from Britain to South Africa

before 1910, “A medical El Dorado?” Colonial medical income and practice at the Cape’, *Soc. Hist. Med.*, 1995, 88(3): 463–79.

<sup>19</sup> Crowther and Dupree, op. cit., note 10 above, Table 1.4, p. 23. Seventy-one per cent of the Glasgow cohort and 38 per cent of the Edinburgh were born in Scotland, though, as with TCD, a proportion born overseas might very well have family connections to Scotland.

Table 2

Destinations of the 976 graduates examined 1860–1905 ten years after graduation

Ireland	England Wales and Scotland	Navy and army	Africa	India	Australia and New Zealand	North America	Other, including West Indies	Not In	Total
316	277	137	29	45	27	2	13	130	976
32.3%	28.3%	14%	2.9%	4.6%	2.7%	0.02%	1.3%	13.3%	

Dublin, enjoyed the prestige of an old established school, but only rarely were her medical students drawn from outside Ireland.<sup>20</sup> For other Irish medical schools the number of non-native students was even less. By the end of the nineteenth century these schools were recruiting predominantly from within Ireland and even from the surrounding locality.<sup>21</sup>

The majority of medical emigrants, as shown in Table 2, ended up in practice in England and exhibit a settled life conforming to the common experience of the average general practitioner of the time. Charles Emilius Ross graduated from the Royal College of Surgeons in 1875 and by 1885 was practising in Worcester where he remained for the remainder of his professional life. He worked as a surgeon at St Mary's Cottage Hospital and at Tenbury Dispensary. To these duties he added those of district medical officer of Tenbury Union and surgeon to the Odd Fellows and Foresters Assurance Company. He was still at Tenbury in 1904. His career paralleled ones in Ireland such as that of William James Browne. Browne graduated the same year as Ross also from the RCS via the private Ledwich Medical School and Mercer's Hospital. He worked at the Coombe Hospital, Dublin, and eventually settled in Church Hill, Letterkenny, Donegal, where he was medical officer for the Dispensary, district medical officer attending the Royal Irish Constabulary and resident surgeon to the Londonderry County infirmary and City Fever Hospital. These two individuals represent the majority who eventually achieved the desired objective of a practice plus public emoluments and relatively settled professional status.

<sup>20</sup> Between 1860 and 1890, 124 first year entrants to Trinity College medical school were examined. Only four gave their birthplace as England, and, of these, two were external students. Of the other 13 born outside Ireland, all except one—born in Brussels—were from the colonies or ex-colonies and, in some cases of parental occupation such as minister, shipmaster or army officer, it is likely that their fathers had some connection to Ireland or to Trinity. See Trinity College Dublin Manuscripts Room, TCD MS 758, an index of matriculations for the Trinity College School of Physic or Medicine, 1850–1915.

<sup>21</sup> In the case of the medical schools of the Queen's Colleges local recruitment was much more common. For example, of the 456 students attending Queen's College, Belfast, 1908–9 (all faculties), only 25 were from outside Ireland (11 from England). 94.5 per cent were Irish born, and 90 per cent, or 410 of the total, were from the nine counties of Ulster and only 21 from other parts of Ireland. *The report of the president of Queen's College Belfast for the year 1908–9*, PP 1909, vol. XX, Cd. 4831 (715), p. 25, Table I.

### Medical Incomes

One frequently quoted cause of emigration was the poverty of Irish doctors in comparison with their counterparts elsewhere in the United Kingdom. A picture of the poverty-stricken Irish Poor Law doctor has come to dominate the historiography of the Irish medical profession. However, comparisons between the financial situation of Irish and English practitioners show a more complex situation. Anne Digby's book on the medical profession in the late nineteenth and early twentieth century has examined the income of general practitioners in England in 1877, 1899 and 1909.<sup>22</sup> According to their gross annual income, Digby divides general practices into four categories. These are: "small", those which provided an average income of between £300 and £399 per annum; "standard", those yielding between £400–£599 and £600–£799 annually; "good", those producing an annual income of £800 to £999; and "first class", those yielding £1,000 to £1,499, together with a small number worth over £1,500. She suggests that, in 1877, three fifths of country practices in England were "standard practices" and a remaining fifth divided between small and first class. Urban practices, on the whole, provided greater opportunities for average higher incomes. Professional overcrowding in the 1890s led to an increase in the number of small practices but, by 1909, the figures had returned to the 1877 configuration. Digby attributes the recovery of income in that period to the decline in overcrowding in the profession produced by a drop in the number of recruits to medical schools in the 1890s.<sup>23</sup>

Among the sources she used was the *Report of the Committee to inquire into the causes which tend to prevent sufficient eligible candidates from coming forward to the Army Medical Department, 1878–1879*. This examined the level of remuneration for medical officers in the armed services in comparison with the opportunities available to medical graduates outside.<sup>24</sup> Digby quotes from this to the effect that a new graduate might expect to obtain an income of £300 per annum "within 5 years of commencing practice", which would rise to £500 within 10 years and peak at around £800–£1,000—standard to good—towards the end of a career.<sup>25</sup>

The report also covered Ireland and replies about medical incomes in Ireland were received from the medical schools at Queen's College, Belfast, and, in Dublin, the Carmichael Medical School, Dr Steevens' Medical School and the Catholic Medical School. None of the advice suggested significant differences between Ireland and England and Wales. The Carmichael Medical School believed, with a few exceptions, that the usual course for a graduate in Ireland was to seek a dispensary medical officer's post. The rate of pay was £90 to £140 per annum plus fees for acting as registrar of births and deaths, and for vaccination—a further £30 to £50 per annum. To this a part-time

<sup>22</sup> Anne Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720–1911*, Cambridge University Press, 1994, Table 5.2, p. 144. This is based on an analysis of practices for sale. See also *eadem*, *The evolution of British general practice 1850–1948*, Oxford University Press, 1999.

<sup>23</sup> Digby, *Making a medical living*, op. cit., note 22 above, p. 145.

<sup>24</sup> *Report of the Committee to inquire into the causes which tend to prevent sufficient eligible candidates from coming forward to the Army Medical Department*, PP 1878–9, vol. XLIV C.2200 (44) pp. 304–5.

<sup>25</sup> Digby, *Making a medical living*, op. cit., note 22 above, p.143. This is calculated for single handed practices.

appointment as medical officer of health at £10 to £20 per annum was usually added. So the entire fixed income for a newly graduated doctor in Ireland was £120 to £220 per annum. According to the representative of the Carmichael School, “The private practice it would of course be impossible to gauge but it may be stated that there is hardly any district in Ireland where it would not be worth at least £150 a year.”<sup>26</sup> This gave an average starting salary for doctors of £270 to £370, comparable to that in Britain. This might be even higher if one of the more lucrative public appointments was secured. As the Carmichael School representative commented, “The County infirmaries and lunatic asylums are more valuable but they are obtained with more difficulty.”<sup>27</sup>

The consensus among the Irish medical schools as a whole was that a medical graduate could expect an income of £280 to £360 (small by Digby’s calculations) at the start of his career. Ten years later he would earn a standard to good income—£800 to £1,000 according to Dr Steevens’ Medical School, and £500 according to the medical school of Queen’s College, Belfast. Twenty years into a career this would rise to a standard income of £700, according to the Queen’s College medical school in Belfast, a figure surpassed by Dr Steevens’ Medical School’s calculation of £800 to £1,000 (good) after ten years. The trajectory of a medical graduate’s career in Ireland, therefore, was not unlike that of his English counterpart. Starting modestly, the expectation was that, after ten years, income would rise to the standard level and in some cases even reach the “good”. In fact the general tenor was positive. The representative of the medical school of the Catholic University joyfully recounted, “I am frequently astonished at the incomes former pupils enjoy and at the substantial proofs of material prosperity that families and homes present.” This included a student who, after ten years, was earning £900.<sup>28</sup> Medical schools might be expected to put the most favourable gloss on the rewards of medical practice in Ireland because, as will be outlined in the course of this article, they had a vested interest in encouraging recruitment. To put flesh on the bones of the situation, therefore, a more detailed examination has been made of the incomes of doctors in the region of Ballinasloe whose medical practitioners have been examined in 1875 and in 1895.<sup>29</sup>

### Medical Practitioners in Ballinasloe

Ballinasloe is a country town situated in County Galway in the largely rural, western province of Connaught. Its population in 1871 was 5,052. In the census of 1891 it had declined to 4,642.<sup>30</sup> The total population served by its medical practitioners would,

<sup>26</sup> *Report*, op. cit., note 24 above, Appendix D ‘Selection from replies on the probable average earnings of civil medical practitioners’, p. 304.

<sup>27</sup> *Ibid.*, p. 304.

<sup>28</sup> *Ibid.*, p. 304.

<sup>29</sup> All population figures have been taken from W E Vaughan and A J Fitzpatrick (eds), *Irish historical statistics: population, 1821–1971*, Dublin, Royal Irish Academy, 1978. The *Irish Medical Directory* (published by the Irish Medical Association, IMA) has been used for 1875 and 1895 and cross-checked

with the list for Ireland from the UK register. What comes to light from the cross-checking is that compiling directories is not an exact science and, whilst the figures for doctors are roughly comparable, sometimes names are in one directory but not another. Given the probability that the IMA was likely to have more up-to-date knowledge and, for example, published rates of remuneration for all individual public appointments, their names have been used.

<sup>30</sup> The population is given as 3,911 in the *Irish Medical Directory* for 1873, but Vaughan and



of course, be larger, including villages and rural areas in the surrounding districts. Ballinasloe was relatively prosperous, though rural poverty could be found in the hinterland. Both the *Irish Medical Directory* and the *British Medical Directory* contain a list of doctors for the town of Ballinasloe for 1875 and 1895. The two lists are not identical.<sup>31</sup> However, in 1875, in both lists there is a core of six doctors recorded as practising in Ballinasloe. By 1895 this has risen to eight active medical practitioners.<sup>32</sup>

In 1875 Robert V Fletcher took over from R Eaton as the medical superintendent of Ballinasloe lunatic asylum. This was the most lucrative public appointment in the district, and Fletcher went on to enjoy a long career in this position. His salary for 1875 was estimated at £450 per annum, plus £145 in allowances, giving him a “standard” income of £595 from a public appointment. Fletcher, a graduate of Edinburgh in 1865 and the Royal College of Surgeons in Ireland in 1869, had been, before taking up the appointment at Ballinasloe, assistant resident physician at Downpatrick and then at Waterford Asylum. Twenty years later in 1895, Fletcher was still at the Ballinasloe Asylum but his salary had risen to £650, plus £150 allowances, qualifying by Digby’s criteria as a good income.<sup>33</sup>

The lunatic asylum provided remuneration for the medical fraternity of Ballinasloe in general. In 1875, Dominick Burke was visiting and consulting physician there at a salary, on 31 December 1873, of £125 per annum. He was also the medical officer of the Ballinasloe Workhouse from which he earned £120. To this he added a further £18 as consulting sanitary officer, £15 for various duties as medical officer of health, and £18 for work as executive sanitary officer. This was a total of £296 from the public purse alone. In 1895 James J Delahunt, who had graduated in 1879, succeeded him as consulting physician at the lunatic asylum. His salary was £120 per annum with none, apparently, of the accumulated additions which Dr Burke had secured in 1875. But Dr Delahunt also added dispensary work at £120 per annum, plus £14 for vaccination. This made a total of £254 for Delahunt from public appointments.<sup>34</sup> Dr Michael Comerford (graduated 1862) and Dr Eaton (graduated 1855 and 1856) also held positions at the asylum probably for *ad hoc* consultations for neither are down in the *Irish Medical*

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Fitzpatrick’s corrected figures have been used in the subsequent account. Ballinasloe is not typical in the sense that only around a third of the Irish population were living in towns of over 2,000 in 1900. The small country town was, however, an important part of Ireland’s geographical and social landscape. Ballinasloe can also be singled out in having one of the largest lunatic asylums in Ireland.

<sup>31</sup> For example, in the 1875 *Irish Medical Directory*’s town list mentions two doctors not on the British town list, one of whom, however, is a recent graduate and one an elderly doctor who graduated in 1838. Both subsequently disappeared very quickly from the Irish list,

<sup>32</sup> There were eleven doctors listed between both town lists of which eight were new names and three also appear in the 1875 *Irish Medical Directory*. Two of these, however, were recorded as retired from practice.

<sup>33</sup> Figures from the *Irish Medical Directory* for 1875 and 1895. These list the salaries of all doctors in various branches of the public system in Ireland.

<sup>34</sup> These were not the only opportunities for collecting public appointments for Irish doctors or their counterparts in England. In factory districts posts as certifying surgeons were available, coroners’ courts paid fees to doctors, there were medical officers for military camps and naval bases, appointments at county infirmaries and fever hospitals (an MO at an Irish county infirmary could be paid from £40 to £250 per annum in 1875). The pay for MOs in prisons ranged from £60 to £415 averaging around £150 in 1897. See *Irish Medical Directory*, 1897, p. 335. Registration of births and deaths involved fees. Added to this was part-time work for Friendly Societies and insurance companies, and medical work for the Royal Irish Constabulary.

*Directory* as receiving regular salaries. But Dr Rutherford in 1875 got £50 per year as apothecary for the inmates, a sum which had risen to £125 in 1895.

The dispensary work in 1875 was looked after by Dr Patrick Horne. Ballinasloe Dispensary was one of six in the Ballinasloe Union and Dr Horne earned £120 for this, plus £6 6s. for vaccination. This was the highest paid and most populous dispensary district in the Union. Dr Thomas Kearns in Ahascragh earned £50 and Dr E P Sharkey, who graduated in 1833 and retired in 1885 due to “old age”, got £100 in 1875 for work in the Creagh Dispensary.<sup>35</sup> In 1891, according to the annual report of the Local Government Board for Ireland, the six dispensary districts of Ballinasloe between them had an average salary of £121, ranging from £118 to £143 10s.<sup>36</sup>

A 1903 book published to help medical practitioners deal with their financial accounting listed three examples of typical income upon which the author based model tax returns. These, ranging between £435 and £710, may be taken as a reasonable guide to the accepted level of medical incomes. From the study of Ballinasloe doctors, incomes in this range were within reach of all of them.<sup>37</sup> But this would have been on the important assumption that, as the Irish medical schools maintained in 1878–9, a minimum of £150 per year through private practice was available. It is here that the financial strains on Irish doctors appeared.

### Income of Irish Poor Law Officers

Sir Thomas Lough MP, in a speech to the Irish Medical Schools’ and Graduates’ Association in 1905, made reference to the on-going dispute on the remuneration of Irish Poor Law officials. According to Sir Thomas, “Fifty years ago their salaries had been fixed (as they were in England) on the supposition of private practice. This was an erroneous comparison to make now for, while the private practice still remained in England, it had departed, with a great many other good things, from Ireland.”<sup>38</sup> Private practice had not departed from Ireland. In fact, the disposable income of Irish families was increasing in this period and some of it found its way into doctors’ fees. There were towns in Ireland with a rising population in which a good medical living could be made. In 1875 Bangor, a prosperous seaside town within commuting distance of Belfast, had four doctors; this number had risen to twelve in 1908 to meet an almost threefold increase in population.<sup>39</sup> None the less, the situation with regard to private practice was not uniform throughout Ireland and, in certain areas, it was being squeezed by the falling population. This meant diminishing prospects for private practice. Thus in seven country towns with rural hinterlands, though the number of doctors shrank from 39 to 32

<sup>35</sup> *Annual report of the Local Government Board (Ireland)*, PP 1890–1, vol. XXXV (35), p. 216.

<sup>36</sup> *Ibid.*, p. 269.

<sup>37</sup> J Henry May, *Medical practitioners’ accounts*, London, Gee, 1903.

<sup>38</sup> Banquet of the Irish Medical Schools’ and Graduates’ Association, *Journal of the Irish Medical Association*, April 1905, 5: 88. Sir Thomas Lough,

Liberal MP and Home Ruler, was the author of various pamphlets on Irish finances.

<sup>39</sup> See *Irish Medical Register*, and Vaughan and Fitzpatrick, *op. cit.*, note 29 above (using Census of 1911). Bangor’s population rose from 2,560 in 1875 to 7,776 in 1908. It had four doctors in 1875 and twelve in 1908.

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*Table 3*  
Ratio of doctors to population in towns decreasing in size

Place	Pop. 1871	No. of doctors 1875	Ratio of pop. per doctor	Pop. 1911	No. of doctors 1908	Ratio of pop. per doctor
Charlville, Co. Cork	2,482	6	413.6	1,925	4	481
Thurles, Co. Tipperary	5,008	5	1001.6	4,549	7	649.8
Dungarvan, Co. Waterford	6,520	5	1304	4,977	3	1659
Ballina, Co. Mayo	5,843	4	1460.7	4,662	5	932.4
Westport, Co. Mayo	4,417	5	883.4	3,674	4	918
Ennis, Co. Clare	6,503	10	650	5,472	8	684
Fethard, Co. Tipperary	2,106	4	526.5	1,473	1	1473
Total	32,879	39	843	26,732	32	835

*Source:* W E Vaughan and A J Fitzpatrick (eds), *Irish historical statistics: population, 1821–1971*, Dublin, Royal Irish Academy, 1978, and the *Irish Medical Register*.

between 1875 and 1908, the proportion of medical practitioners to the total population of the towns increased from 1 to 843 in 1875, to 1 per 835 in 1908.

In Ireland population decline meant that the magic words for those seeking a practice expressed in an exchange of letters in B W Lara's correspondence book dealing with the sale of practices in 1881, "the population is large and increasing" applied only to certain regions.<sup>40</sup> In addition, the use of the dispensary system, not just by the very poorest but by a large proportion of the non-pauper population, was considered by the Irish medical profession to aggravate the problem of private practice.<sup>41</sup> According to one disaffected Irish doctor, "The dispensary medical officers have been and are compelled to attend on tickets numbers of persons who have no claim whatever to gratuitous attendance."<sup>42</sup>

The problem particularly affected the rural practitioner. The more straitened circumstances of rural practitioners, arising from a combination of fewer opportunities for private practice and the greater costs of travel, have been noted by Digby for England. They were more "economically precarious" and such a situation must have been replicated to a

<sup>40</sup> Archives and Manuscripts, Wellcome Library, London, MS 3170, B W Lara & Co. Letter-book (dealing with the sale of medical practices) 1881, p. 443.

<sup>41</sup> The same point has been made by Irvine Loudon in relation to hospital outpatient departments;

see I S L Loudon 'Historical importance of outpatients', *Br. Med. J.*, 15 April 1978, i: 974–7.

<sup>42</sup> 'A retrospect of the Irish Poor Law dispensary, lunatic asylum and workhouse systems: I. The Poor-Law dispensary system', *Br. Med. J.*, 3 Jan. 1903, i: 27–8, p. 27.

much greater extent in Ireland.<sup>43</sup> Cases of extreme penury were often cited in support of the Irish doctors' 1903–5 campaign to improve the pay of Poor Law medical officers. Drumconrath, the rural dispensary district of one west of Ireland doctor, was described as a place which in former times was fairly populous:

But owing to the depression in agriculture of the last quarter of a century, cultivation has practically ceased, and the land is used for grazing only. As a result the labouring population has greatly decreased, a few herdsmen sufficing for large tracts; and whereas in 1851, when the dispensary districts were formed, the total population was some 27,000, it is now barely half that . . .

The story of the late medical officer of Drumconrath is one of the saddest among many such in the Irish Poor-law service. When he was appointed medical officer, more than fifty years ago, the district was a good one for private practice: he was a clever practitioner, and was able to live comfortably, and the salary of the dispensary was an item of small importance. By degrees the economic causes referred to deprived him of his private practice, and at 76 years of age . . . he found himself in bad health, too old to work, and with no money saved . . . With no refuge but the workhouse, as his pathetic letter to the guardians pointed out, this poor old man, victim to the Irish dispensary system, in a moment of despair put an end to his too-long life.<sup>44</sup>

Poor Law salaries for Irish doctors were eventually raised. Undoubtedly this added to the prosperity of those doctors already in good practices but was probably of only limited help to practitioners in the rural west.<sup>45</sup> Sir William Thompson, physician to the Lord Lieutenant in Ireland, commented in 1905 on how far an income of £120 a year for dispensary doctors, which had become standard, would suffice in the absence of private practice. He averred that “to a man in a large town, allowed to engage in private practice, this might be a considerable sum”. A rural practitioner in the west might, however, only make £10 to £30 per annum in private practice. So that for this class of doctors,

. . . in what were known as the congested districts inhabited by people who had scarcely the bare necessities of life, where there were no resident landlord class, practically no shop-keeping class and the country consisted of bogs or mountain sides sometimes thirty or forty square miles in extent, one could imagine how far £130 would go in supporting and feeding possibly a married man with children.<sup>46</sup>

There were good livings available to the medical practitioner in Ireland but there were also doctors struggling at the margin. Some illustration of the relative situation as between Ireland and England can be given in a comparison of the wills of Irish and English doctors during this period. Several important caveats are required in using this measure. First, wills indicate wealth. As we know from the history of the Darwin family so ably recounted by Janet Browne, whereas Erasmus and Robert Darwin were both successful doctors, much of their wealth came from their industrial or financial connections, not their professional medical labours.<sup>47</sup> Given fewer opportunities for industrial or

<sup>43</sup> Digby, *op. cit.*, note 22 above, p. 145.

<sup>44</sup> ‘Notes on Ireland’, *Br. Med. J.*, 14 Jan. 1905, i: 91.

<sup>45</sup> The breakthrough came in new scales of salaries for the North Dublin Union sanctioned by the Local Government Board (Ireland) and reported in October 1904. This was a signal of a relaxation on the upper limits to salaries in the Poor Law service which, after that date, spread throughout the system.

Issue after issue of the journal of the IMA began publishing evidence of a general rise in salaries among the Poor Law service. See Greta Jones unpublished paper. ‘The doctors’ strike’, given to the Glasgow Conference of the Society for Social History of Medicine, 3–5 Sept. 2008.

<sup>46</sup> *J. Irish Med. Assoc.*, Jan. 1905, 6 (1): 4–5.

<sup>47</sup> Janet Browne, *Charles Darwin: voyaging*, 2 vols, London, Jonathan Cape, 1995, vol. 1, pp. 6–9.

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commercial wealth in Ireland, though there were some, the larger proportion of substantial fortunes among English doctors probably reflected the relative state of industrial and commercial development between the two countries. Ireland had some wealthy doctors but not as many as England. It also had a greater tail of doctors leaving bequests at the more modest scale of under £999.

*Table 4a*  
Bequests of those reaching the age of fifty and above, 1876–1910: Ireland\*

Wills	Numbers	Percentages
Under £999	32	26
£1,000–£2,900	31	25
£3,000–£4,999	15	12
£5,000–£9,999	18	15
£10,000–£19,999	14	11
£20,000–£49,999	11	9
£50,000–£100,000	2	2
£100,000 +	–	
Total	123	

\*Names were compiled at random from obituaries in the *British Medical Journal* and cross-checked with Probate Records for Ireland and England. Where age at death was not available, the date of first medical qualification in the *Medical Directory* was taken and a nominal age of twenty-five at this point was given. All subsequent years until the date of death were added to this age. This does not give an accurate age at death but, checking the procedure against instances where age at death is given, it provides a reasonable guide to whether the person falls into the age range of over fifty years at death.

Sources: obituary lists in the *British Medical Journal* and probated wills in Ireland (Public Record Office of Northern Ireland).

*Table 4b*  
Bequests of those reaching the age of fifty and above, 1876–1910: England

Wills	Numbers	Percentages
Under £999	19	15
£1,000–£2,900	31	25
£3,000–£4,999	12	9.5
£5,000–£9,999	15	12
£10,000–£19,999	22	17
£20,000–£49,999	20	16
£50,000–£100,000	2	2
£100,000 +	2	2
Total	123	

Sources: obituary lists in the *British Medical Journal* and probated wills in the Probate Office, London.

Of doctors practising in Ireland, 26 per cent were leaving less than £999 compared with 15 per cent in England. When it came to fortunes of £10,000 to £20,000 and higher, the percentage of Irish doctors also begins to fall compared with their English counterparts. This leaves, as was suggested, more doctors in Ireland with smaller bequests and fewer with substantial bequests. However, this still means that the rewards of medical professional labour in Ireland were such that just under 50 per cent were leaving respectable legacies.<sup>48</sup> So, although more work needs to be done on medical income and occupational structure in Ireland, it is probable that, whilst good livings were available from private practice, there was a greater number of doctors, many of them in the rural west, struggling to build up private practice. It is a reasonable conclusion that, whereas Digby was able to conclude that three fifths of doctors in England and Wales had standard to good practices, the proportion in Ireland falls short of that.

### Emigration

Throughout the period 1860–1960, Irish medical schools routinely produced more graduates than could be absorbed in Ireland. This was accepted by the medical schools as a matter of course. The Commission on Higher Education 1960–7 advised that “recognising that emigration of Irish doctors has been a characteristic feature of modern Irish society and impressed by the evidence we received on the subject, we think that in any calculation of the number of Irish doctors to be trained, allowance must be made for emigration”.<sup>49</sup> Ireland produced, in fact, a remarkably high proportion of the total number of medical graduates in the British Isles as a whole. Keetley’s *Student’s guide to the medical profession* (1878) opined, “If the number of students be considered, the Medical School of Dublin is larger than that of London, or indeed any other town of the United Kingdom.”<sup>50</sup> In 1871, according to the General Medical Council’s register of first year entrants into approved medical schools, England, with 72 per cent of the population of the British Isles, produced 44.9 per cent of first year registrants. The remainder came from Scotland and Ireland who, with 27.7 per cent of the population between them, produced 55 per cent of first year medical students in the British Isles. However, in Scotland the population was rising during this period whereas in Ireland it was falling. But Irish medical schools continued to produce around a fifth of first year entrants to medical schools in the British Isles well into the interwar years.

One important outcome was the dependence of the Irish university system, as a whole, upon the medical student. The historian of the medical school of the Catholic University points out that the survival of the Catholic University was wholly due to its ability to attract students aspiring to a medical degree, whose fees saw it through its early years.<sup>51</sup> Queen’s College, Cork (a constituent member of the National University of Ireland from 1908), was also frank about the importance of the medical student to its survival. In an obituary of Bertram Windle, president from 1904 to 1919, the College, at the

<sup>48</sup> See Crowther and Dupree, *op. cit.*, note 10 above, Table 10.1, p. 357, for estate values for their cohort of graduates from Scottish schools.

<sup>49</sup> *Report*, *op. cit.*, note 2 above, p. 246.

<sup>50</sup> Charles B Keetley, *The student’s guide to the medical profession*, London, Macmillan, 1878, p. 81.

<sup>51</sup> Meenan, *op. cit.*, note 5 above, p. 44.

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*Table 5*  
Percentage of first year medical registrants for each jurisdiction to total number of registrants and to percentage of population of UK

Year	England and Wales		Scotland		Ireland	
	%Population	%First Year Registrants	%Population	%First Year Registrants	%Population	%First Year Registrants
1871	72.2	44.9	10.6	27.0	17.1	28.0
1881	74.5	49.0	10.68	26.1	14.8	24.8
1891	76.9	54.38	10.6	30.3	12.4	15.3
1901	78.5	44.7	10.7	37.02	10.7	18.2
1911	79.7	42.28	10.5	36.9	9.6	20.7
1920		43.4		35.9		20.6
1925		46.3		38.3		15.3
1930		44.1		36.9		18.9
1936	81.46*	50.3	9.87*	29.5	8.6*	20.4

\*After partition, the dates at which censuses were taken differ between Ireland and Britain for a short time. Therefore when calculating the 1936 figures, the England and Wales, and Scotland census of 1931 was used, but the figures for Ireland were taken from Vaughan and Fitzpatrick's figures for the 1936 Irish population. See W E Vaughan and A J Fitzpatrick (eds), *Irish historical statistics: population, 1821–1971*, Dublin, Royal Irish Academy, 1978, Table 3, p. 3.

Sources: computed from Census, and 'Summary of the number of medical students registered during each year, in each of the three divisions of the United Kingdom from the commencement of Student's registration in 1865 to the end of the year 1915', *Medical and Dental Students' Register*, London, General Medical Council, 1936, p. 15, and 'Summary of the number of medical students registered during each year in each of the three divisions of the United Kingdom, from 1905 to 1936 inclusive', *ibid.*, p. 18.

time when he assumed the presidency, was described as "little more than an excellent medical school which manufactured doctors for export".<sup>52</sup> The figures bear this out. In the years 1894–6 medical students accounted for around 84 per cent of the total number of students. Although this proportion dropped in the next two decades, in 1906–7 medical students still made up around two thirds of Cork's student body. Although Galway was less dependent, in 1880 57.6 per cent of the students were studying medicine. The figure fluctuated but was still around a third in 1905–6. Galway's failure to attract as many medical students as other Irish universities was, however, the reason why it was considered the most vulnerable of the Queen's Colleges in Ireland.

The medical student declined in importance as Ireland moved into the twentieth century and especially when, after the Second World War, the total numbers in higher education began to rise.<sup>53</sup> Though this did not mean that, in absolute numbers, there were fewer medical students, it did mean that they declined as a percentage of the student

<sup>52</sup> John J Horgan, 'Sir Bertram Windle: an appreciation', *Cork University College sessional lists 1928–9*, pp. 119–28. Windle died in Canada in 1929.

<sup>53</sup> In independent Ireland the numbers of full-time students rose from 4,978 in 1938–9 to 8,653 in 1959–60 and 13,006 in 1964–5. *Report*, op. cit., note 2 above, vol. 1, Table 12, p. 31.

body.<sup>54</sup> None the less, each year between 1860 and 1875 there were, on average, over 1,000 medical students in Ireland, and the same is true for the period 1938–65 for the twenty-six counties of Eire alone, a remarkable continuity in a shrinking population. Irish universities were not entirely institutions for turning out doctors but, realistically, for much of the late nineteenth and early twentieth century, this was their chief function.

This meant that the Irish middle classes who invested in a medical education for their sons—and eventually their daughters—were aware that emigration might be the outcome. Though the decision to emigrate arose, in some cases, after protracted attempts at setting up practice in Ireland, in other instances, it was expected and planned for. Emigration to England could involve considerable further expenditure on top of the costs of a medical education itself.

A writer, giving advice to the newly qualified graduate of Irish schools in 1868, commented on the financial aspect of relocation in England. There were a lucky few who obtained some public appointment in England as the basis for starting a career there, but “much better than this, however, is the purchase of a partnership or the transfer of an English practice”.<sup>55</sup> However, a practice in London was expensive and “will fetch two years purchase”, and in the southern counties “a good practice of £500 a year will require a year’s purchase especially in a market town”. Less was paid for a Midlands’ practice and less still for northern ones except in the “best towns”. Thus the new graduate would need to invest at least £300 to £500, or £1,000, but with the result that “we have known several young medical men who have done so and who are now making a large annual income, much larger than if they had remained in this country”.

Thus the purchase of a good practice in England required considerable resources.<sup>56</sup> But even those who worked in poorer parts of urban England could tell tales of medical prosperity. Robert Esler, a graduate of Queen’s College’s medical school who worked in Peckham as a police surgeon, told his compatriots in 1890 that a good living could be made by a popular, hardworking doctor even in the poorest areas of London: “Within the four mile radius there are mixed practices . . . But I am asked what about the 6d. men? Some of them do very well indeed. I know of one man whose practice consists mainly of club patients and 6d. fees who has two horses and as many carriages.”<sup>57</sup>

For the less wealthy family, purchase of a practice could be made with a bank loan, loans from relatives, or by an arrangement allowing for a share in a practice to be paid back by regular deduction from subsequent earnings. Borrowing from insurance

<sup>54</sup> In 1938–9 medical students formed 30.19 per cent of those studying in the universities in independent Ireland. *Report*, op. cit., note 2 above, calculated from vol. 1, Table 73, p. 242, and Table 23, p. 47. These figures are an underestimate for they do not include the College of Surgeons which educated between 300 students annually during the twenty years for which figures are calculated.

<sup>55</sup> ‘The existing professional prospects of young men entering on practice’, *J. Irish Med. Assoc.*, 27 May 1868, no. 23: 89–91, p. 90.

<sup>56</sup> The process was often carried out by an agency specializing in this kind of transaction and in a surviving book from a such an agency—B W Lara &

Co. in London for the year 1881—we get some idea of the value of practices. The prices quoted for practices in England were £600 for a practice in York which “yields nearly £700 a year”. Others passed hands at prices of over £1,000. Shares are offered in practices from £300 to £600 at half or one third. A practice could be had for £500 down and the remainder at the end of the year taken out of the receipts.

<sup>57</sup> Robert Esler MD, ‘On some experiences of medical practice in the metropolis’, *Transactions of the Ulster Medical Society*, Session 1890–1: 68–75, p. 69.



companies was another route. Occasionally, foreclosure of a run down, debt ridden medical practice meant it could be bought at a bargain price. The assumption was that the purchaser of a practice would also accede to the part-time public health and Poor Law appointments which had been held by the previous incumbent. This was not certain, but as another guide to starting a medical career put it, “It is well known that public appointments are often a leading element in the value of a practice.”<sup>58</sup>

Another route, which relied on family resources, was through an assistantship to a doctor in general practice, especially one that held out the prospect of succeeding to a partnership or the practice itself. The Carmichael Medical School, in the evidence they gave to the committee on remuneration in the army medical service in 1878–9, stated, “It may be added that many Irishmen at the beginning of their professional career buy partnerships in practices in England or act as assistants with the view of succeeding to a share in or the whole value of a general practice.”<sup>59</sup> A writer on the travails of a medical life in 1867 discussing assistantships in medical practices, asserted, “Whatever may be the cause, the fact is indisputable that a very large number of the qualified men who are now open to engagements are either Irishmen or Scotsmen.”<sup>60</sup> The Irish author of ‘Prospects of professional young men’ in 1868 claimed, “In a pecuniary point of view, even an assistant to a general Practitioner in England is much better off than a Poor Law Medical Officer in this country; his pay will be at least as good, he will have no expense and a horse will be kept for him when required.”<sup>61</sup>

Around a fifth of the graduates studied between 1860 and 1905 opted for medical service in the armed forces or the Indian Medical Service. From 1863 all candidates for the IMS together with those for the army and navy medical services had to take a one year course of study at the Royal Army Medical College at Netley leading to an exam.<sup>62</sup> Even with the additional expense involved in this, a medical career in the military did not have the risks associated with setting up in practice if money, friends or connections were in short supply. It was regular work, pay increased on active service, and retirement on half pay was allowed after twenty years. There was also a progression from assistant surgeon to surgeon and then surgeon major. A pattern is observable in military careers where, by retirement, most had at least a few years in the rank of surgeon major. Even before the

<sup>58</sup> Percival Turner, *Hints relating to the sale and purchase of medical and dental practices and partnerships*, London, [1932?], p. 22.

<sup>59</sup> *Report . . . into the causes . . . to prevent eligible candidates . . . to the Medical Department*, op. cit., note 24 above, Appendix D, ‘Selection from replies on the probable average earnings of civil medical practitioners’, p. 304.

<sup>60</sup> John Baxter Langley, *Via medica: a treatise on the laws and customs of the medical profession in relation especially to principals and assistants with suggestions to students on preliminary education*, London, 1867, p. 35.

<sup>61</sup> *J. Irish Med. Assoc.*, 27 May 1868, no. 23: 90. Reproduced from a supplement to the *Medical Press and Circular*.

<sup>62</sup> Mark Harrison has noted the predominance of Irish medical school graduates in the Indian Medical

Service. Those claiming Ireland as their birthplace comprised 10.5 per cent of the total for 1837–54, 26.2 per cent for 1855–84, and 12.6 per cent for 1885–96. See Mark Harrison, *Public health in British India*, Cambridge University Press, 1994, p. 31, Table 1.3. Scotland had more in the IMS in the first period, 22.7 per cent in 1855–84, but was overtaken by Ireland in the last two, 19.1 and 8.3 per cent respectively. Spencer H Brown estimates that between 1840 and 1909 45 per cent of surgeons in West Africa and the West Indies were Irish. See Spencer H Brown, ‘British army surgeons commissioned 1840–1909 with West Indian/West African Service: a prosopographical evaluation’, *Med. Hist.*, 1993, 37: 411–31, Table 2, p. 419. This compared to 12.1 from Scotland and 32.6 from England.

increases in income recommended by the 1878–9 committee, the initial starting salary matched and even exceeded the immediate pay of public appointments—except for lunatic asylums and some county infirmary boards.<sup>63</sup> The report of 1878–9 recommended improvements in the pay and conditions of those serving as doctors in the army and colonial service, and this meant in 1885 retirement on a £1 a day pension and an honorium of over £2,000, allowing for the possibility of purchasing a practice. Moreover a military career had positive attractions. It offered a wide range of opportunities, and some doctors made notable careers out of the army and IMS.

All these economic calculations influenced decisions about emigration. But it is also important to emphasize another point. Some medical emigrants to Britain looked upon emigration as the “last resort” driven by relative poverty; others found the additional costs it might incur a burden. But Rosemary Stevens’s observation about another generation of medical migrants—that they did not always come from the poorest families—also applies.<sup>64</sup> Emigration could offer the possibility of a distinguished and lucrative medical career elsewhere. The lure of rewards and honours stimulated emigration, and many saw it in this light. For some families, therefore, emigration was the first choice rather than the last resort.

Migration to Britain was based on the assumption of a common medical marketplace, a similarly regulated profession and cultural affinities. It was not until 1922, on the independence of twenty-six counties, that it would involve—for a part of Ireland only—crossing national borders. Even then, no formal legal barriers existed to the movement of labour between the two islands. Ireland’s medical schools were still represented on the General Medical Council of the United Kingdom and subject to periodic inspection by the GMC.

Was it therefore emigration? Whatever the links, migration to Britain was certainly seen as removal. A distinct sense of difference and of nationality remained. One of the more visible manifestations was the Irish Medical Schools’ and Graduates’ Association founded around 1877.<sup>65</sup> By 1880 there were 189 members. Most practised in Britain where the Association’s annual meetings and dinners were held. By 1888 there were 514 practitioners on its roll.<sup>66</sup> It could not be said to have covered all emigrant Irish medical graduates, and 1899 Dr Stewart, the provincial honorary secretary, claimed that there were “2,000 practitioners resident in Great Britain who were eligible for membership but were not yet enrolled”.<sup>67</sup>

<sup>63</sup> According to the *Report* of 1878–9 (see note 24 above) on remuneration of doctors in the services, an assistant surgeon could obtain £200 per annum on appointment rising to £273 after ten years, and a surgeon major £529 after fifteen. After ten years an honorium of £1,000 was payable, which meant that it was possible to contemplate setting up in practice.

<sup>64</sup> Rosemary Stevens and her colleagues studied doctor immigrants to the USA in the 1960s. Among them were a high proportion from the developing world whom, it was assumed, were driven by poverty. They pointed out, however, that the typical doctor immigrant was often from the better off and well connected medical family. James N Haug and

Rosemary Stevens, ‘Foreign medical graduates in the United States 1963 and 1971: a cohort study’, *Inquiry*, 1973, **10**: 26–32, and Rosemary Stevens, Louis Wolf Goodman and Stephen S Mick, ‘What happens to foreign trained doctors who come to the United States?’, *Inquiry*, 1974, **11**: 112–24.

<sup>65</sup> The 11th annual meeting was on 24 March 1888, which takes us back to 1877 as the year of its foundation. The second annual meeting was recorded in Cork 1879.

<sup>66</sup> ‘Irish Medical Schools’ and Graduates’ Association’, *Br. Med. J.*, 24 March 1888, **i**: 659.

<sup>67</sup> ‘Irish Medical Schools’ and Graduates’ Association’, *Br. Med. J.*, 5 Aug. 1899, **ii**: 385.

Part of the Association's remit was to represent the particular grievances of Irish medical emigrants—particularly the preference given in some appointments in England to the degrees and diplomas of the London colleges.<sup>68</sup> At the same time the convivial atmosphere of its annual dinners, to which distinguished visitors were invited, were also an opportunity for the celebration of Irish patriotism and uniqueness. At the annual dinner of 1880 held in Cambridge there was a particularly eminent company of visitors. “Mr Lister said he never dined in the presence of Irishmen without feeling an irrepressible sense of envy for the natural gift of eloquence that had been bestowed on them”, whilst Dr Brown-Séguard confessed “his grandmother was an Irish woman and so he possessed a little of that blood”. Dr Gross of the USA said he “recollected when quite a boy in his profession, with what benefit and what interest he read many works emanating from the Dublin press, he had been charmed with the writings of the late lamented Stokes and the like lamented Graves—names engraved in the heart of every Irishman who knew anything of medicine”.<sup>69</sup>

This sense of national identity could take various forms. Turner J Fisher, a graduate of Queen's College, Belfast, in 1875, after taking a master's degree, relocated to 14 Portland Place, Lower Clapton, in London, and then moved to Hackney. Over the years he collected various emoluments, becoming by 1885 medical officer for the General Post Office and for the fourth and fifth districts of the Hackney Union, as well as officer for the London Clerks Association and the Old Gravel Pit Association. He remained in London throughout his professional life, his last appearance in the *Medical Directory* being in 1920. Fisher, none the less, named his house in Hackney “Carnalea” after a small village near Bangor, County Down. Robert Esler, his fellow graduate from Queen's College, Belfast, in 1875, began his career at the Ulster Hospital for Women and Children, becoming president of the Ulster Medical Society. His strong commitment to the area is shown in his publication of a guidebook of the scenic beauties of Antrim in 1884, and a history of early Belfast medicine in the same year.<sup>70</sup> But by 1885 he had moved to Peckham. His duties there included, as well as general practice, the post of medical officer for the “P” division of the Metropolitan Police. Esler's address was still in Peckham in 1915. Though removal to England attenuated his links with Ulster, he retained professional and personal connections with Ireland. He published in 1887 in the *Transactions of the Ulster Medical Society* on ovariectomy, and in 1890 on his experience as a police physician in London. Esler summed up his feelings on his departure in this fashion:

I miss your Medical Meetings—the Medical Societies of London are four miles distant—and I miss my many old friends. I have no Dill nor Whitla nor M'Kenzie to interchange ideas with, nor have

<sup>68</sup> In 1888: “Much satisfaction was expressed at the success of Sir Thomas Crawford in inducing the British Medical Association at its annual meeting last August in Dublin to pass a resolution condemnatory of monopoly in hospital appointments. The Council is now in communication with the Irish qualifying bodies and hopes, with their aid, in time to remove some of the disabilities at present affecting Irish degrees and qualifications in England.” ‘Irish Medical Schools’

and Graduates' Association', *Br. Med. J.*, 24 March 1888, i: 659.

<sup>69</sup> ‘Irish Graduates' Association', *Br. Med. J.*, 4 Sept. 1880, ii: 407–9, p. 408.

<sup>70</sup> Robert Esler MD, ‘Early history of medicine in Belfast’, *Transactions of the Ulster Medical Society*, Session 1885, pp. 17–28. The ‘Guide to Belfast, the Giant's Causeway and the North’, 1884, was prepared as a guide-book for the visit of the British Medical Association to Belfast.

I any hospital work nor student classes to prepare for; but I have, in exchange, a remunerative practice, good health, a happy home and am a citizen of no mean city.<sup>71</sup>

### Conclusion

For most of the period 1860–1960 Irish medical schools were exporting schools. Assumptions that they would produce more graduates than could be absorbed in Ireland were built into their calculations. There was an expectation that opportunities for making a medical living outside Ireland would routinely be considered upon graduation or shortly after. This influenced advice and admonitions to graduates. Parents and students accepted that this might be the outcome of a medical education. For those who remained in Ireland, a medical career could provide similar emoluments to those in England. A stratum of doctors existed in Ireland whose rewards from medical labour were commensurate with the respectable incomes of their English counterparts. But there were, at the margins, poorer rewards from private practice, leading to greater dependence on the Poor Law appointment. This acted as a push factor for emigration.

However, it was not always the poorest—those with diminished opportunities in Ireland, or those who were disappointed in their expectations of making a medical living there—who emigrated. Emigration represented opportunity too. The anticipation of a good living in England, the excitement of the metropolis or larger town, and the opportunities provided by empire also exerted a pull upon the Irish medical graduate. Sir Thomas Myles, addressing the graduates of the Royal College of Surgeons in Ireland in 1901, put this choice to his audience. They could embrace “a life of servitude” aggravated by the “insane competition for the position of dispensary doctor” against “a vista of success in one of the large towns of England or subsequently settling in one of the colonies”. He was not, he opined, “urging you to emigrate; to do so would, I know, bring down on me the wrath of many well meaning people who think that Irish workhouses are not sufficiently overcrowded”. But he urged graduates to “shake themselves free from the spirit of narrow parochialism and strike out boldly for the big prizes that are available to you”. This meant that: “It is our fashion to rail against the British Empire and all that pertains to it. But don’t forget that under the flag of that Empire and thanks to the growth of that Empire, thousands of Irish medical men are making a comfortable living and hold posts of honour and emolument in every part of the globe.”<sup>72</sup>

<sup>71</sup> Esler, *op. cit.*, note 57 above, p. 75.

<sup>72</sup> Thomas Myles, President of the RCSI 1900–2, ‘Military and dispensary appointments’, address to

the RCSI, *J. Irish Med. Assoc.*, 1901, **1** (12): 89–91, pp. 90–1.