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GENDER, MEDICINE AND THE STATE IN IRELAND, 1852–1922

Ciara Breathnach

Introduction

By 1905, Henry Wellcome was extremely wealthy from his patent medicine endeavours and he was populating the eponymous Historical Medical Museum with ethnographic curios and scientific implements from all over the world. Modern or 'Western' medicine, itself a contested term but generally agreed to mean clinical or evidence-based practice, had made such an impact globally that Wellcome was moved to collect vestiges of traditional medicine before they were lost to history. He wrote to Robert J. Welch, a professional Belfast photographer who would later achieve international acclaim as the official Harland and Wolff, or Titanic, photographer, in search of visual representations of Irish folk medicine. Welch responded:

> In reply to your circular I am not prepared to exhibit as it would be utterly useless to me + I am excessively busy at Irish Scientific work in connection with the Royal Irish Academy … I can however supply you with a class of photos you cannot get elsewhere … I can supply Rag and other Votive well, stills at work, healing stones, some very famous ones too. The Tobernavean Hole Stone that cures rickets in children by passing them thro. The Inishmurray Hole-Stone that the women pray at, before childbirth (always). The Aran Hole Stone thro which sick women's linen is passed.[1]

Despite the passage of 54 years since the establishment of a public healthcare system, it was underused by the rural poor in particular and people continued to rely on folk beliefs and unqualified practitioners for primary medical needs. What is most poignant about this correspondence is what it reveals about the strength of belief in folk cures for maternity care and serious medical conditions such as rickets. Indeed

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there is plenty of evidence to show that people adopted a combination of traditional and 'qualified' medical and nursing expertise throughout this timeframe and well into the twentieth century. Holy wells were also central to healing practices and married elements of religious beliefs and magical healing (discussed in further detail by Sneddon).

In rural Ireland, and in County Sligo where the Tobernavean Hole Stone was located, women in childbirth were at high risk and infancy and childhood were the most dangerous life cycles in urban areas.[2] Maternal and infant mortality are highly sensitive national wealth and public health indicators, and both mortality rates remained stubbornly high well into the twentieth century. The year Wellcome and Welch had their exchange of letters, childbirth accounted for 639 deaths registered nationally,[3] 227 were from puerperal fever, representing 2.2 of every 1,000 live registered births (102,832).[4] Infants (under 12 months) accounted for 9,792 deaths of the total number of 75,071 registered and a further 15,123 children aged between 1 and 5 years of age died. By way of comparison, old age accounted for 8,641 deaths.[5]

In brief, gastro-intestinal diseases gave rise to the majority of the infant and child deaths which were concentrated in urban areas and were associated with poverty, insanitary tenements, poor water quality and feeding practices. In rural areas, infants fared better but deaths of mothers in childbirth were more prevalent. I have argued elsewhere that maternal mortality was underreported as registrars often opted for underlying or other causes of death and were not obliged to include pregnancy. High maternal mortality in remote areas also points to the absence of, or poor engagement with, what we might term 'qualified' maternity care. I posit that trust in local 'modern' medical services was often trumped by allegiances to traditional practitioners in rural Ireland, who were more accessible than qualified midwives and doctors. The persistence of folk medicine well into the twentieth century owed much to the way in which public healthcare evolved after the 1851 Medical Charities Act, and, as Sneddon's chapter argues, it co-existed with scientific-based medicine and crossed religious divides.[6] This chapter traces the legislation that underpinned the system to outline why by the 1920s people were selective in their engagement with modern medicine and, using the National Folklore Collection records, it concludes by outlining how folk medicine endured during this era of modernisation.

A mixed medical economy and power

In order to understand the mixed medical economy it is first necessary to place the public healthcare system in its wider political and socio-cultural contexts. Ireland occupied a constitutionally ambiguous position in British imperial terms and, as Alvin Jackson argues, the Act of Union enacted in 1801 was 'incomplete'.[7] Resources were unequally distributed and the majority of the Irish population was poor. Economically, the country's backward agricultural system struggled to compete in a Four Nations context and, with the repeal of restrictive tariffs in the post-Napoleonic War era and the introduction of *laissez-faire* economics, even

less so in a global marketplace. These macro-economic forces rendered the poor even more vulnerable to inevitable shocks, occasioned by fluctuating prices or crop failures. Famines, starvation and food shortages occurred periodically throughout the nineteenth century and poverty was both cyclical and pervasive.[8] Even Dublin City, which had a more diverse economic profile, saw a marked shift from its rapid growth in the late eighteenth century to decline in the first three decades of the nineteenth owing to the loss of sovereignty.[9] The urban and rural elite fled to the social circles of London and indeed the upper middle classes fled from the city centres to the suburbs and thus the Georgian townhouses built for single family usage became overcrowded tenements containing up to 12 households.[10] The 1901 and 1911 manuscript census returns are remarkable primary sources that are available to search for free online and provide plenty examples of the degree to which Dublin City had been reduced to tenements. Rural Ireland also saw the flight of landowning classes and in their absence subdivision of smallholdings in the West of Ireland proceeded unchecked (see Rachel Murphy's contribution). These uneconomic holdings combined with a reliance on the mono-carbohydrate diet of potatoes to create a range of new vulnerabilities for the already impoverished population. Exponential population growth occurred in the late eighteenth century and while the records are flawed it is estimated that the population was in the region of 8.2 million when the Great Famine occurred in the 1840s.[11]

Accurate vital registration information arising from census data was and continues to be one of the most effective instruments of public health. But this element of 'biological citizenship', as Nikolas Rose terms it, also formed the basis of taxation and other governmental policies.[12] For the poorer classes, who were not subject to much by way of taxation, this new form of power over personage and bodies revealed many other insecurities, not least the fear of what we would now term 'surveillance'. Among the biopower measures British administration introduced were the decennial censuses conducted from 1821 to 1911 and the introduction of civil registration in 1864.[13] Denominationalism hindered both efforts. During the reign of Henry VIII, the Church of Ireland became the official state church, but the vast majority of the Irish population rejected the reformed religion and remained Roman Catholic. Despite the imposition of Penal Laws in the seventeenth century, which aimed to decimate Roman Catholicism and other cultural attributes (see Wolf's contribution on the decline of the Irish language), by 1861, 4,505,265 still professed that faith as against 691,872 members of the Established Church. These statistics bolstered the argument of the Liberal prime minister, William Gladstone, to disestablish the Church of Ireland in 1869.[14] I will return shortly to the matter of counting the living and dead, but it is first necessary to establish an outline of how local structures of public healthcare emerged.[15]

By 1801 there were few recourses for the poor to receive government aid, and the network of Houses of Industry established in the late eighteenth century was far from comprehensive.[16] With respect to public healthcare provision for the sick poor, the system was dominated by an unsustainable public/private funding model. Dispensaries, much like modern-day general practice settings, relied completely

on voluntary subscriptions, or charitable donations and were unevenly dispersed because, as Laurence M. Geary notes, 'philanthropy rather than necessity dictated the number and location … in pre-Famine Ireland'.[17] Following the Act of Union, the dispensary system received some state support under the 1805 Dispensaries Act, which tethered their management to County Infirmaries until 1818.[18] An Act to establish a county infirmary (hospital) system was passed in 1807 but, like its 1765 predecessor, outside of Ulster it had limited success owing to inadequate funding.[19] There was also a network of fever hospitals. Medical healthcare provision for the sick poor was funded primarily through voluntary subscriptions, and even when the government provided funding these amounts had to be matched by locally raised subscriptions. Publicly funded psychiatric hospitals were established from 1817 and, as Oonagh Walsh's chapter shows, the district lunatic asylums were strategically located to cater for large geographic regions.

It was when impoverished Irish people created social problems as migrants in England, Scotland and Wales, as public health risks and their willingness to work for cheaper wages, that it was decided to establish some form of poor relief in Ireland. A royal commission chaired by Richard Whately was established in 1833 to investigate the matter of Irish poverty. By virtue of the scale, nuance and considered approach, Whately discovered in his three-year inquiry that a spectrum of poverty existed in Ireland and the lines between the poor and destitute frequently blurred. The commission was criticised, as Virginia Crossman notes, for overextending its reach as it was only supposed to consider destitution, or the very bottom tier of Irish society. It offered a series of recommendations to address the matter of financial precariousness, including public works to generate employment and assisted migration schemes. The recommendations were ignored.[20] Lord John Russell, then Secretary of State of the Home Office and later Prime Minister, sent English Poor Law Commissioner George Nicholls with a more pointed mission, to assess the prospects of establishing the English poor law system in Ireland.[21] England and Wales had had a poor law in place since the Elizabethan era, and the separate system was established in Scotland in the late sixteenth century.[22] In 1834, the English and Welsh system was reformed, adopting the principles of 'less eligibility'.[23] Christine Kinealy explains that this so-called 'New Poor Law' was 'designed to ensure that dependency on poor relief was less attractive and materially less comfortable than the life of even the poorest independent labourer'.[24] Although completely unsuited to the nature of poverty in Ireland, which had a much broader range of problems than the proposed solution could deal with, in 1838 the Irish Poor Law was enacted.[25]

The Irish system had a Board of Commissioners that created a new network of 130 'Unions', which were based on the existing district electoral divisions. Each union was placed under the control of a 'partially elected' board of guardians, which Peter Gray describes as 'a major innovation to the Irish body politic'.[26] Although significant changes occurred with the foundation of the poor law, power brokerage remained in the same hands –mainly the landed gentry (see O'Riordan's chapter) and mercantile classes. Guardians were empowered to build a workhouse where

'indoor relief' was administered, and activities were funded by a rate or tax levied at a local level. Deviating little from the previous pressures on local subscriptions for fundamental public services, the idea was that Irish property owners would pay via rates for Irish poverty. Powers of election were vested in the ratepayers and invariably guardians were drawn from the local elite and voters were ratepayers in good standing. The maximum number of votes per person was 18 and their allocation was aligned to respective levels of rate-payment. This property requirement had inevitable gendered and class-specific consequences: in the first instance it included very few women (as Tiernan's and Ward's chapters show); and the majority of men were also excluded from having a voice. Modelled on the 'New Poor Law', the system that was introduced had draconian admission criteria and pitted undeserving (able-bodied poor) against the deserving poor (widowed, orphan and infirm). In order to receive any form of relief initially the poor had to be inmates of the workhouse. Men and women were separated on entry and children could be separated indefinitely from their parents. Sarah-Anne Buckley deals with this matter in greater detail in her chapter. There were some grudging aspects to the Irish system that did not pertain in England: there was no right to relief initially and the Extension Act of 1847 included the so-called 'Gregory Clause', which required tenants to give up land in excess of a quarter acre to qualify for indoor relief. Although repealed in 1862, it seems to have had a long legacy in terms of engagement with the system in rural areas.[27]

While several famines and failed harvests causing food shortages and starvation happened throughout the eighteenth and early nineteenth centuries, the Great Famine (1845–1852) led to at least one-eighth of the Irish population dying. The poor law system was designed to meet the needs of the destitute, which Nicholls, in his capacity as poor law commissioner, estimated at a population of 80,000. But when the potato crop failed repeatedly in the 1840s the consequences were so devastating that millions were plunged into dire circumstances. During the Famine, the poor law apparatus was used to deal with the fundamental matters of indoor and later outdoor relief and it was quickly overwhelmed. The workhouses were simply not designed to meet the challenges that the resulting economic and social crisis created, and it not could not cope with the volume of resulting destitution. The historiography of the Famine is vast and despite the flawed figures of the early census returns, scholars such as Ó Gráda and Mokyr posit that of the estimated 8.5 million population, approximately one million died and a further two million emigrated (see Fitzgerald's contribution) during and in its aftermath.[28] Geary has argued that apart from dietary-related illnesses, like scurvy, there were fevers that were specific to the Famine; in addition, the unfortunate coincidence of a cholera outbreak in 1849 was another reason for the excess mortality. Typhoid and typhus were also at uncontrolled levels of transmission. Characterised by rash, fever and delirium, typhus led to an inevitable painful death.[29] But, it was 'Famine fever' that wreaked the greatest devastation, and not just in Ireland. When some 116,000 Irish Famine refugees arrived in Liverpool in 1847, many of them carried these virulent pathogens with them. Darwen et al. contend that because they arrived to a perfect

set of overcrowded, poor and insanitary conditions in Scottish and English cities epidemics were inevitable. With a certain degree of blame and stigmatisation, these disease outbreaks earned the sobriquet 'Irish fever', reinforcing the poor relation status in the Four Nation project.[30] In Ireland, a different type of gendered stigmatisation occurred; Margaret Kelleher has argued that the Famine was feminised as a way of reconciling its impact and, as Aidan Beatty's chapter shows, it also became a symbol of national emasculation.[31]

Ireland was ill-equipped to deal with the level of destitution and concomitant disease, so provisions in the 1838 Act were used to establish an inquiry into the existing medical services. Notwithstanding his limited experience of Irish administration and how unpopular he was in Ireland, George Nicholls was given the responsibility. A large part of the survey was to establish the number of entities in receipt of funding from Grand Jury presentments. The survey surmised that a total of 64 dispensaries,[32] 101 fever hospitals and 41 county infirmaries were in receipt of funds. His survey provided the basis for the Poor Relief (Ireland) Act 1851, more commonly known as the Medical Charities Act, which brought the matter of medical relief under the poor law.[33] It consolidated prior acts associated with public healthcare schemes, which included dispensaries and fever hospitals, and placed them under the auspices of the poor law.[34] Poor law unions, numbering 163 at that point, were further divided into 723 dispensary districts, which served as the infrastructure for a range of services and public health campaigns. Invariably union hospitals, dispensaries, maternity services, healthcare in the home (public health) and vaccination stations were operated by the same medical officer. Geary states that in reality these officers, who were elected annually by the Guardians, were poorly paid and the real value of the local authority post was in establishing a professional profile for private practice.[35] The wealthier classes O'Riordan describes in her contribution to this volume, and indeed the rising Roman Catholic middle classes, would have accessed medicine as private fee-paying patients. When the Local Government Board was established in 1872, it became responsible for the administration of the poor law and replaced the Poor Law Commissioners.[36]

Civil registration of births, deaths and marriages commenced in England and Wales in 1837.[37] Various attempts to introduce a full vital registration system to Scotland failed until 1854.[38] In the interim a limited form of civil registration was introduced to Ireland: from 1 April 1845, all non-Catholic Irish marriages were to be registered by the civil authorities.[39] The road towards a full system for Ireland was more contentious, but eventually an act for civil registration of births and deaths was passed in 1863 and came into operation on 1 January 1864. Apart from the establishment of a General Register Office in Dublin, overseen by a Registrar General of Births and Deaths, the process was grafted onto the poor law and dispensary doctors were charged with the task of registration births and deaths in their districts.[40] So sceptical of the mortality returns was Dr Thomas Wrigley Grimshaw, the Registrar General of Ireland from 1879 to 1900, that he began to use burial records to correct the Dublin figures. Elsewhere I have discussed the matter

of poor engagement with civil registration and indeed there is evidence to support the fact that in remote areas life event underreporting lasted until the 1990s. Throughout the nineteenth century the influence of the Roman Catholic Church grew exponentially and its sacramental rites of baptism, marriage and death were more carefully observed than mandatory civil registration. It is for such reasons that Irish population returns must be viewed with a critical eye. Compulsory smallpox vaccination was also ushered in with civil registration in 1864. Deborah Brunton, in her comprehensive study of smallpox vaccination, has argued that there was 'substantial underreporting of births' and posits that the Irish claims to eradication in the 1880s are dubious.[41]

In broad terms most of the Irish population was poor and Roman Catholic and registered doctors were predominantly both middle-class and male, which must have had a bearing on engagement with the flawed quasi-social welfare system that was mapped on to the dispensaries and union hospitals.[42] Significant shifts occurred in local administration, with an increasing number of politically nationalist members as the nineteenth century progressed. By then Ultramontanism (beyond the Alps, or strict adherence to the teachings of Rome) was making significant gains in Ireland and the role of the clergy in all aspects of Irish life was becoming more defined in education and medical services (see Roddy's and John Walsh's chapters). Fear of proselytism, or the potential for religious conversion to Protestantism, troubled the Irish Roman Catholic bishops greatly and the provision of a free, if untrained, nursing was an effective way of ensuring that the sick poor were not at risk. The Congregation of Mercy was an Irish order established by Catherine MacAuley in Dublin in 1836 and the Sisters of Mercy were permitted to take over some nursing care in the Union hospitals from the 1860s onwards.[43] Opinions on their benefit were divided but the gradual shift in power into their hands helped to reconcile the Irish difficulty with resorting to the 'Union hospital' for medical care.[44] In Dublin, the Sisters of Charity ran the North and South Dublin Union Children's wards, which were regularly criticised in newspapers for high mortality rates. The 'nursing nuns' had no formal training and were prohibited from conducting several clinical duties in accordance with edicts of canon law that stretched back to the thirteenth century, for example maternity care, surgical, male and night cases. Nonetheless, they helped to maintain order and cleanliness in Union hospitals. A survey carried out in 1903 showed that 415 nuns were working in the system, many worked for free.[45]

Until the 1898 Local Government Act the management of the dispensaries was overseen by non-medically trained local committees comprising poor law guardians and ratepayers; in other words, the elite of an intensely localised system.[46] Local relieving officers, who were paid employees with no medical training, decided who received access to care using a ticketing system; treatment at a dispensary was afforded by a black ticket and a red one permitted a home visit from the dispensary doctor.[47] Doctors could refer people to the union hospital as appropriate. The legacy of 'less eligibility' had an impact and engagement with the public health services varied from region to region. In large urban settings, where anonymity was afforded

by sheer numbers, the poor used the dispensary and union hospital services more, but in rural areas it was not uncommon for poor people, especially those living in remote areas to die, without ever having availed of their entitlement to free medical assistance.

Two inquiries were established in the early twentieth century to establish the efficacy of the poor law and its healthcare capacity. The Vice-Regal Commission on Poor Law Reform recommended in 1906 that the workhouses be shut down and appropriate accommodation be erected for the sick poor. According to its evidence, in 1905 there were 8 City Infirmaries (4 in Dublin, 2 in Cork and one each in Limerick and Waterford), 34 County Infirmaries, 14 Fever Hospitals, which was a significant reduction from the pre-Famine number of 90, some had been repurposed in the interim to become 'Poor Law hospitals'.[48] The report noted how the sick poor constituted 14,491 of the total workhouse population of 45,195, 14,380 were aged and infirm, 5,900 were children and there were 2,129 'unmarried mothers'. The remainder was made up of 4,667 able-bodied, 3,165 classified as insane and 463 epileptics.[49] It was estimated that 8,204 of the patients in the union hospitals and county infirmaries were suffering from tuberculosis (pulmonary is inferred).[50] Although levels of engagement with public healthcare had improved, in 1909 it was found that unqualified practitioners were thriving in 137 of the 158 unions. In that survey, the findings in Killarney, County Kerry were similar to elsewhere, people delayed seeking 'competent medical advice', used unqualified midwives and chemists prescribed independently of dispensary doctors.[51]

Another inquiry reported in 1919 that

> there has grown up an enormously complicated system of local health administration, the result is that few persons, apart from the officials directly concerned, understand the system or from what sources advice or assistance in regards to hospital treatment, or to questions pertaining to public health generally, can be obtained.[52]

It recommended that a separate ministry for health be established for Ireland, that Boards of Guardians be divested of control over union infirmaries and fever hospitals and that these powers be transferred to an envisioned system of Health Boards organised along county or county borough lines.[53] Essentially it recognised the necessity of streamlining control and recommended that it be 'freed from association with Poor Law administration'.[54] Outside of metropolitan areas, memories of the workhouse were often appropriated to the worst attributes of British occupation. By the 1930s, when the following story was collected under the aegis of the Irish Folklore Commission the 'workhouse' came to occupy a specific place in popular memory.

> The Workhouse was built in 1841. In the famine years it was full up of people who had no food to eat and other houses were used as workhouses. … The People who died in the workhouse were buried in *Teampall Bán*. In the year

> 1920 the workhouse was closed and the poor people were removed to the County Home in Killarney.
>
> The house next to the workhouse was turned into a convent in 1891. The Mercy nuns lived here. Before that this house was occupied by a party of British horse-soldiers called the Scots' Greys. … In 1922 the workhouse was burned down by the Republicans and at the present time a new hospital is being built.[55]

In this retelling, the history of the Listowel workhouse site is intertwined with Famine memory. Later in the timeline, the Sisters of Mercy, in ousting the occupying Crown forces from an adjacent house, had a cleansing affect and the last vestiges of colonialism were purged by fire set by Irish Republican anti-Treaty forces.[56]

The Great Famine dominated the Irish mindset for generations; to those who were born after the event and therefore could not remember it, it had morphed from living memory to become, what Chris Morash terms, a 'semiotic system of representations' and the workhouse was central to that.[57] As it became the locus for relief measures, the negative associations between the workhouse, Famine, starvation and disease were never severed and, as Laurence M. Geary has cogently argued, it was 'was unreservedly hated by those it was supposed to relieve'.[58] Peter Gray makes a similar observation and contends that workhouses were 'irrevocably associated with the horrors of mass mortality during the Great Famine … associated with the suffering and degradation of their inmates'.[59] While Olwen Purdue and others have argued that in some instances there was a certain degree of agency in how the poor interacted with the system in the late nineteenth century, there were regional variations. For tenant farmers who aspired to owner occupancy submission to the workhouse not only signalled economic ruin; it was also the epitome of moral failing.[60]

Conclusion

This chapter has outlined the architecture of public healthcare provision to show why a mixed medical economy persisted well into the twentieth century. For gendered, class and cultural reasons, the poor law and its associated medical services embodied several disincentives to engagement. As the nineteenth century progressed, a more fluid relationship developed between the 'union' and urban inhabitants who engaged more frequently. They used it to stretch individual and household resources to their maximum yield. The history of Irish engagement with 'qualified' medical care is a complicated one, and it is little wonder that a system grafted to the poor law had limited success. For such reasons, a mixed medical economy combining elements of modern and traditional medicine co-existed throughout this era.

There are many further research avenues that could be fruitfully pursued using freely accessible sources, especially if they adopt gendered, transnational, colonial and postcolonial analytical frameworks. Local authority archives have placed their holdings online, and it is possible to trace regional engagement with 'the Union'

through these records.[61] Traditional medicine and healers featured strongly in the 1937 Irish Folklore Commission School's Collection and this large body of primary sources are freely accessible on dúchas.ie. Further to this a large selection of British Parliamentary Papers and the text of primary legislation are available freely online. The *Oireachtas* (Irish National Parliament) Library has digitised much of its historical holdings.[62] Where possible here I cited digital object identifiers (DOIs) of secondary readings, many of which are available on open access.

From 1851 until 1920 the management and duties of public healthcare complicated the ways in which people understood medico-legal power. Denominationalism complicated matters even further; Roman Catholicism was often vocally opposed to nationalist activities but, by 1922, both were inextricably linked. This went some way towards encouraging greater engagement with social welfare in the decades that followed in Roman Catholic-run hospitals. When the Commission on the Relief of the Sick and Destitute Poor published its report in 1927 it found that widows and their children, orphans, unmarried mothers and their children and deserted children were among the chief occupants of the erstwhile nineteenth-century workhouses.[63] That some became sites of 'mother and baby' homes is also telling of the way in which workhouses were reimagined as places of moral rectitude. The Department of Local Government and Public Health established in 1925 was a behemoth with responsibilities that stretched from vital infrastructure to healthcare provision. In practical terms, the Irish Free State could do little to enact the recommendations of the 1927 report because of the lack of funding. A hospital sweepstake was established in the 1930s to assist with funding from voluntary subscriptions. Instead of breaking the bonds between healthcare and charity, it served the regressive function of entrenching them.

Notes

1 Wellcome Archive/WA/HMM/CO/Ear/1041: Box 67. Letter from Robert Welch to Henry S. Wellcome, February 15, 1905.

2 Ciara Breathnach, "The Triumph of Proximity: The Impact of District Nursing Schemes in 1890s' Rural Ireland," *Nursing History Review* 26, no. 1 (January 2018): 68–82; Ciara Breathnach and Brian Gurrin, "Maternal Mortality, Dublin 1864–1905," *Social History of Medicine* 31, no. 1 (February 2018): 79–105; Ciara Breathnach and Brian Gurrin, "A Tale of Two Cities – Infant Mortality and Cause of Infant Death, Dublin, 1864–1910," *Urban History* 44, no. 4 (2017): 647–677.

3 British Parliamentary Papers, Forty-second detailed annual report of the Registrar General for Ireland, containing a general abstract of the numbers of marriages, births, and deaths registered in Ireland during the year 1905 [Cd. 3123], xxii.

4 Ibid., xxi, xi.

5 Ibid., xiii. In 1905 the primary causes of death were pulmonary tuberculosis and bronchitis which caused 11,882 and 7,462 deaths respectively across all age categories. Heart disease, which was more prevalent in adult age cohorts, caused 8,170 deaths.

6 An act to provide for the better distribution, support and management of medical charities in Ireland; and to amend an act of the eleventh year of her majesty, to provide for the execution of the laws for the relief of the poor in Ireland (1851), 14 & 15 Vict., c.68.

7 Alvin Jackson, "Ireland, the Union, and the Empire, 1800–1960," in *Ireland and the British Empire*, ed. Kevin Kenny (Oxford: Oxford University Press, 2004), 123–153 at 124.

8 Christine Kinealy, *A Death-Dealing Famine: The Great Hunger in Ireland* (London: Pluto Press, 1997).
9 Mary E. Daly, *Dublin, the Deposed Capital: A Social and Economic History, 1806–1914* (Cork: Cork University Press, 1984), 2; David Dickson, *Dublin: The Making of a Capital City* (London: Profile Books, 2014).
10 See for example http://census.nationalarchives.ie/pages/1901/Dublin/Mountjoy/Summerhill/. Accessed August 27 2021. House number 11, originally designed for one family, was partitioned into 8 separate rooms.
11 Timothy Guinnane, *The Vanishing Irish: Households, Migration, and the Rural Economy in Ireland* (Princeton, NJ: Princeton University Press, 1997), 79–89. Joel Mokyr, *Why Ireland Starved: A Quantitative and Analytical History of the Irish Economy, 1800–1850* (Boston, MA: George Allen and Urwin, 1983), 30–80.
12 Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton, NJ: Princeton University Press, 2006), 139–141.
13 An Act for the registration of births and deaths in Ireland (26 & 27 Vict. 11), 1863.
14 BPP, Return of Number of Roman Catholics and Number of Members of Established Church in Ireland, 1834 and 1861 [289].
15 Irish Church Act 1869 (32 & 33 Vict. c.42).
16 Laurence M. Geary, "From Voluntary Hospitals to Voluntary Health Insurance: A History of Irish Healthcare from the Early-Eighteenth to the Mid-Twentieth Century," in *The Irish Healthcare System. An Historical and Comparative Review* (Dublin: Health Insurance Authority, September 2018), 9–27. https://www.hia.ie/sites/default/files/The%20Irish%20Healthcare%20System%20-%20An%20Historical%20and%20Comparative%20Review_0.pdf. Accessed 30 August 2021.
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18 Ibid., 54–63.
19 County Infirmaries (Ireland) Act 1807, 5 Geo. 3. c.20.
20 Niall Ó Ciosáin, "The Poor Inquiry and Irish Society – A Consensus Theory of Truth," *Transactions of the Royal Historical Society* 20 (December 2010): 127–139. https://doi.org/10.1017/S0080440110000083.
21 Virginia Crossman, *Politics, Pauperism and Power in Late Nineteenth-Century Ireland* (Manchester: Manchester University Press), 8–9.
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23 An Acte for the Releife of the Poore, 1601, 43 Eliz 1 c 2.
24 Kinealy, *A Death-Dealing Famine*, 38.
25 Crossman, *Politics, Pauperism and Power*, 9.
26 Peter Gray, *The Making of the Irish Poor Law, 1815–43* (Manchester: Manchester University Press, 2009), 293.
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35 Geary, "The Medical Profession," 189–206.
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40 Act for the registration of Births and Deaths in Ireland, 1863, 26 & 27 Vic., c.11; An Act to provide for the Registration of Marriages in Ireland, 1863, 26 & 27 Vic., c.90.
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47 Ruth Barrington, *Health, Medicine and Politics in Ireland, 1900–70* (Dublin: Institute of Public Administration), 7–8. Barrington also argues that the further duty of Medical Officer of Health created a conflict for doctors and 'the arrangement did little to improve environmental conditions for public health since the obligations of the MOH often conflicted with the interests of private practice'.
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50 Ibid., 24.
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61 Huge credit is due to the network of County Archivists, Niamh Brennan (Donegal) and Rene Franklin (Clare) deserve special mention, who have gone to enormous lengths to find funding and had the foresight to make these records available for free online https://tipperarystudies.ie/poor-law-union-records/, https://www.donegalcoco.ie/culture/archives/countyarchivescollection/poorlawunionboardsofguardians1840-1923/, https://www.clarelibrary.ie/eolas/archives/poor_law_unions.htm all. Accessed August 28, 2021.
62 For a selection of BPP pertaining to Ireland see https://www.dippam.ac.uk/eppi for statutes, see http://www.irishstatutebook.ie/, https://www.bailii.org/, for Irish Government sources https://www.oireachtas.ie/en/visit-and-learn/history-and-buildings/historical-documents/. All accessed August 26, 2021.
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