SELECTED WORKS IN THE SOCIOLOGY OF MEDICINE: PUBLISHED WORK SUBMITTED FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

by

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## SELECTED WORKS IN THE SOCIOLOGY OF MEDICINE

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SECTION ONE
The Struggle to Reform the Royal College of Physicians, 1767-1771:
A Sociological Analysis

Medical History, 17, 1973, pp 107-126
THE STRUGGLE TO REFORM THE ROYAL COLLEGE
OF PHYSICIANS, 1767-1771:
A SOCIOLOGICAL ANALYSIS

by

IVAN WADDINGTON

The history of the medical profession in the first half of the nineteenth century is, to a considerable extent, the history of the movement for medical reform. In the course of the development of this movement, a large and growing section of the profession put forward demands for the democratic reform of the medical corporations, for changes in the laws relating to medical practice, and for the reform of medical education. However, the nineteenth-century campaign for medical reform, which eventually resulted in the passage of the Medical Act of 1858, had its social origins in changes in the structure of the profession which were already well under way in the eighteenth century. In this paper, an attempt will be made to outline one of the earlier, and relatively neglected, struggles for reform—that which centred on the Royal College of Physicians in the years 1767-71—and to provide an analysis of the social basis of this struggle. Before this can be done, however, it is necessary to examine briefly the institutional structure of the medical profession during this period.

In the eighteenth century, the law recognized only three types of medical practitioners: physicians, surgeons, and apothecaries. These three groups were organized in a hierarchical structure, with physicians forming the 'first class of medical practitioner in rank and legal pre-eminence'. By the statute of 32 Henry 8 physicians were allowed to practise physic in all its branches, among which surgery was included. However the disdain which physicians, as a body of learned men, felt for manual work, had led to a contraction in their duties. By the eighteenth century, the practice of the physician was held to be properly confined to prescribing of drugs to be compounded by the apothecary, and in superintending operations performed by surgeons in order to prescribe what was necessary to the general health of the patient, or to counteract any internal disease.

The controlling body for physicians was the Royal College of Physicians in London. Established by charter in 1518, the powers of the College were confirmed by an Act of 1522. By this Act, no persons, excepting graduates of Oxford or Cambridge, were allowed to practise physic unless examined and approved by the College. In the course of the development of the College, a distinction had grown up between the

1 J. W. Willcock: The Laws Relating to the Medical Profession, London, 1830, p. 30. The outline of the legal status of physicians and surgeons is based on the work of Willcock, who was an authority on these matters. At the time Willcock wrote, the legal status of physicians and surgeons was much the same as it had been in the mid-eighteenth century, with the exception that both groups were, at the later date, subject to the operation of the Apothecaries Act of 1815.
fellows on the one hand, and the licentiates on the other.® The licentiates simply held a licence to practise medicine in London, and in an area seven miles around London. They were not allowed to take part in the formulation of College policy, nor were they allowed to vote at elections. All political offices and all decision-making functions within the College were monopolized by the fellows, almost all of whom were graduates of Oxford or Cambridge.®

In sharp contrast to physicians, surgeons were regarded as craftsmen rather than gentlemen. The surgeons had been united with the barbers in the Company of Barber-Surgeons until 1745, in which year they formed a separate organization, the Company of Surgeons. The proper sphere of practice of the surgeon was held to consist generally in the cure of all outward diseases, and in the use of surgical instruments in all cases where this was necessary.*

The lowest order of the medical profession, the apothecaries, had been organized in the Society of Apothecaries since 1617. The charter of the Society required seven years' apprenticeship to a member as an essential qualification for admission to the freedom of the company, and stated that at the end of seven years "every such apprentice . . . shall be examined, proved, and tried concerning the preparing, dispensing, handling, commixing and compounding of medicines."® However by the early part of the eighteenth century, the apothecaries had successfully grafted medical on to pharmaceutical practice, and had won legal recognition of their right to do so. Thus apothecaries were able to prescribe, as well as to dispense medicines, though they were entitled to charge only for medicines supplied, not for attendance or advice.®

This traditional tripartite structure of the profession constituted what may be called an estate system of stratification. Thus the 'orders' of the profession were hierarchically ranked, and each grade of practitioner had privileges which were legally defined. The general concept of the qualified or registered practitioner had no place in English law prior to the Medical Act of 1858; instead there were separate laws relating to physicians, to surgeons, and to apothecaries. This brief outline of the structure of the profession is necessary for it will be suggested that the social origins of the reform movement within the College of Physicians in the period 1767–71 are to be found in the emergence of a new type of practitioner who cut across all these professional divisions which were enshrined not only in the legal system, but in the institutional structure of the profession as a whole.

The struggle to reform the College of Physicians was sparked off by an incident

® There was also a third group, the extra-licentiates, who held a licence to practise medicine in England and Wales, excluding the London area. Like the licentiates, they took no part in formulating College policy, and could not vote at elections. They appear not to have been involved in the movement to reform the College.

® In the period 1700–1770, the College admitted 146 fellows. Of this number, 140 held medical degrees from, or had incorporated at, Oxford or Cambridge. Of the others, six had graduated from continental universities, and two from Scottish universities. See Munk's Roll, vols. II.

® This is a very general outline of what was a very complex legal situation. For a more detailed examination of the legal status of the surgeon, see Willcock, op. cit., pp. 56–58.


® It was not until 1829 that apothecaries won the right to charge for advice, and not until the following year that they were entitled to charge for both advice and medicines supplied. See Towne v. Gresley, 5 E and P. 381, and Handey v. Henson, 4 Carr. and P. 110.
involving an obstetrician named Dr. Letch, who had been summoned to be examined as a licentiate. After the examination, however, a muddle occurred when the President took the votes. One of the examiners said that his vote had been counted in Dr. Letch’s favour when really it was on the other side, and if it had been correctly counted the doctor would not have passed. The special general comitia of the College upheld the rejection of Dr. Letch, but in the meantime Dr. Letch had gone to law. The court of king’s bench sent down a rule for the College to show cause why it should not admit Dr. Letch a member. Before the matter came into court, the licentiates had formed themselves into the Society of Collegiate Physicians. Fellows were not to be admitted to its membership and the Society’s main aim was to campaign for a change in the constitution of the College. At its first meeting, held on 16 January 1767, the Society received a note from the Beadle of the College, indicating that the College intended to publish a series of Medical Transactions, and inviting the licentiates to contribute papers. The licentiates refused to do so. Shortly afterwards, they began to collect subscriptions for supporting Dr. Letch’s cause. Dr. Fothergill and Dr. William Hunter each gave £500, and Dr. de la Cour gave £300. Sir Fletcher Norton, a very eminent barrister, was engaged to represent Dr. Letch, while the College engaged Charles York, perhaps the most brilliant barrister of his day. The issue came to court in May 1767. Norton argued that by his election in the comitia minora Dr. Letch had acquired a right to be a member of the College and that the court should enforce the completion of his right by a mandamus. Lord Mansfield, however, did not agree, and found for the College. He did, however, intimate to the College a caution against narrowing their grounds of admission so much, that if even a Boerhaave should be resident here he could not be admitted to their fellowship. Two other judges, Yates and Aston, held that Dr. Letch should have applied for a mandamus to make him a licentiate, not to admit him as a member. This raised the question of whether licentiates were members of the College, and the Society of Collegiate Physicians quickly devised a means to test this.

In June 1767 twenty-three licentiates applied in writing to be admitted as fellows, and the College refused their applications. At the quarterly comitia on 25 June, nine licentiates seated themselves among the fellows, and Dr. Silvester, one of the founders of the Society of Collegiate Physicians, began to address the meeting. On being told that he had no right to debate there, he and the other licentiates insisted they had a right to be heard as members of the corporation. At this point the President indicated that unless the licentiates withdrew quietly, he would be obliged to send for constables, whereupon William Hunter declared that ‘if any Man or Constable offered to lay hands upon him to turn him out of their House [adding for this is our House] he would run him through the body’. Other licentiates agreed to repel force with force. Finding it impossible to transact any business, the President dissolved the comitia.


The litigation is reported in 4 Burr. 2186–2195.

From the summary of events prepared by the solicitor of the College for submission to Council, quoted in Stevenson, op. cit., p. 111. The other licentiates, besides Hunter, were Sir William Duncan, Thomas Dickson, Alexander Russell, Matthew Maty, Alexander Hay, Sir John Silvester, Michael Morris, and Hugh Alexander Kennedy.]
Another meeting of the comitia was arranged for 24 September. At about the time the meeting was due to commence, a group of twenty-one licentiates, accompanied by a gang of hirelings whom they had engaged in a tavern in St. Paul's Churchyard, arrived at the College gates and demanded to be admitted. When they were denied admittance, they broke open the gate and rushed into the courtyard, where they manhandled Mr. Lawrence, the College solicitor, and broke a number of windows. With sledgehammers and crowbars, they then broke open the Hall door, and two other doors leading to the room where the President and fellows were assembled, and sat down amongst them. Once again the President was forced to dissolve the comitia.

More trouble was expected a few days later, for the quarterly meeting of the comitia was due to be held on 30 September. The lock on the gate of the courtyard was specially strengthened, and the College procured a body of constables to repel any invaders. Meanwhile the licentiates met at their usual tavern, where they hired the services of forty ruffians. When they failed, however, to engage a blacksmith, whom they needed to break open the courtyard gate, they decided to drop their plan for another assault on the College, and instead sent a letter to Sir William Browne, the retiring President, demanding admittance to vote in the election of officers of the College. The College sent a written answer, stating that they apprehended the gentlemen who had signed the letter had no right to vote.

After this there was no further violence within the grounds of the College; the 'battle of Warwick Lane', satirized by Samuel Foote in 'The Devil Upon Two Sticks', was over. The licentiates, however, did not give up their struggle, but switched their attack back to the law courts. Sir Fletcher Norton, again acting on behalf of the licentiates, applied for a writ of quo warranto to be filed against the newly elected censors, to show by what authority they acted as censors. The objection was that they were elected by the fellows only, whereas the election ought to have been by the whole body. Lord Mansfield held the question to be whether the persons applying for the writ were fellows, and entitled to vote in the election of censors. He held that the licence to practise did not amount to an admission into the fellowship of the College. The distinction between fellows and licentiates was, he said, as well known as the distinction between graduates and undergraduates in the universities. Justices Aston, Willes and Yates concurred in this view.

Lord Mansfield, however, repeated his advice to the College to consider reviewing their statutes. He thought there were many licentiates who would do honour to the College, and asked 'how can any byelaws, which exclude the possibility of admitting such persons into the College, stand with the trust reposed in them of "admitting all that are fit"?' He saw a source of 'great dispute and litigation' in the byelaws as they then stood.


12 For satirical allusions to the 'battle' in stage plays at the time, see B. C. Corner, 'Dr. Melchisede Broadbrim and the playwright', J. Hist. Med., 1953, 13, 112-33. The text of 'The Devil Upon Two Sticks' may be found in the Works of Samuel Foote, London, 1830, vol. III, pp. 5-57.

13 The litigation is reported in 4 Burr. 2195-2204. Willcock disagreed with the view of Lord Mansfield in this case, holding that the byelaws of the College which restricted the fellowship to graduates of Oxford and Cambridge were illegal, because they imposed a qualification not required by the charter and by the act of incorporation. See Willcock's evidence before the Select Committee on Medical Education, 1834, 602-1, part 1, Q.4113-4116.
Lord Mansfield’s advice was not taken, however, and just over a year later the licentiates brought a third suit against the College. Sir Fletcher Norton, representing Dr. Edward Archer, a licentiate since 1752, moved for a mandamus to be directed to the College, commanding them to admit him into the ‘body and fellowship’ of the College. Mr. Walker applied for a similar mandamus on behalf of Dr. John Fothergill. These motions were intended to try the question whether licentiates had a right, not this time to do business, but to be admitted as fellows. In the case of Dr. Archer, it was again held that the licence to practise did not mean that its holder was lawfully entitled to be admitted a member of the College, and the court refused to grant the mandamus applied for. The application on behalf of Fothergill, heard the following year, was also rejected. Lord Mansfield held that it would be ‘a most unreasonable thing . . . to turn this licence so accepted against the persons from whom it was thus accepted and to set it up as the foundation of a right to be admitted under the charter.’ At the same time he indicated that he had read all the constitutions, statutes, and byelaws of the College, and found many of them ‘narrow, if not illegal’. He concluded by stating that it was now for the College to consider ‘whether they will trust to a return upon these byelaws, or mend them.’

After this case, the College finally set about revising the statutes, and before the new statutes were ready it elected three licentiates as fellows, speciali gratia. Shortly after, two new rules relating to the admission of licentiates into the fellowship were passed. The first of these was that any fellow of the College might propose a licentiate of seven years’ standing and not less than thirty-six years of age to be a candidate. He was then to be examined in Greek, in Hippocrates, Galen and Aretaeus, and a number of other subjects. After his examination the fellows were to ballot on his election. The second rule stated that in each year the president might propose one licentiate for election straight away as a fellow. Miss Hamilton has suggested that these tactics ‘succeeded in splitting the ranks of the licentiates, though very few were actually admitted under the byelaws’. Certainly it is true that the byelaws were rarely used to admit licentiates into the fellowship; after the admission of the three licentiates noted above, in 1771, no more licentiates were admitted until 1784. From this date the new byelaws were used more frequently, and in the period 1784–1790, six licentiates were admitted. However, in spite of the fact that the new byelaws did little to increase mobility between the two strata, it may still be true that the College succeeded in splitting the ranks of the licentiates. It would seem that without knowledge of how the byelaws were to be applied, the licentiates found it difficult to agree amongst themselves as to how the new rules were going to affect them. Thus, while Fothergill held that they were not upon the whole more liberal than the former, William Watson, another founder member of the College, finally set about revising the statutes, and before the new statutes were ready it elected three licentiates as fellows, speciali gratia. Shortly after, two new rules relating to the admission of licentiates into the fellowship were passed. The first of these was that any fellow of the College might propose a licentiate of seven years’ standing and not less than thirty-six years of age to be a candidate. He was then to be examined in Greek, in Hippocrates, Galen and Aretaeus, and a number of other subjects. After his examination the fellows were to ballot on his election. The second rule stated that in each year the president might propose one licentiate for election straight away as a fellow. Miss Hamilton has suggested that these tactics ‘succeeded in splitting the ranks of the licentiates, though very few were actually admitted under the byelaws’. Certainly it is true that the byelaws were rarely used to admit licentiates into the fellowship; after the admission of the three licentiates noted above, in 1771, no more licentiates were admitted until 1784. From this date the new byelaws were used more frequently, and in the period 1784–1790, six licentiates were admitted. However, in spite of the fact that the new byelaws did little to increase mobility between the two strata, it may still be true that the College succeeded in splitting the ranks of the licentiates. It would seem that without knowledge of how the byelaws were to be applied, the licentiates found it difficult to agree amongst themselves as to how the new rules were going to affect them. Thus, while Fothergill held that they were not upon the whole more liberal than the former, William Watson, another founder member of the College.
the Society of Collegiate Physicians said they were more liberal than he could have expected.\[22\]

What is clear is that after the failure of the suits of Archer and Fothergill and the passing of the new statutes, the Society of Collegiate Physicians became much less militant. From 1771 the Society became less involved with problems of medical reform, and took on more and more the character of a friendly and scientific society. Thus the minute-books of the Society indicate that throughout the 1770s and 1780s most of the business of meetings was taken up by dining and listening to reports of cases, medical papers and éloges.\[21\] The reconciliation of the Society with the College was complete in 1784. In that year two members of the Society were admitted to the fellowship. The Society promptly responded by passing three important motions. The first stated that every member shall henceforth be at full liberty to contribute to the Transactions of the College if he so wishes. The second motion stated that since the two members who had been created fellows had continued in membership of the Society, in future any fellows of the College might be proposed for membership, and elected by ballot in the usual way. Finally, it was resolved that ‘in order further to promote the Union and Harmony of this Society, with the Fellows of the College, the President be from henceforth empowered to invite to Dine at the quarterly meetings of this Society, any number, not exceeding Four at a time, of the Fellows of the Royal College of Physicians’.\[22\]

So far we have presented an outline of the development of the struggle between the licentiates and fellows of the College of Physicians; now it is necessary to present a causal analysis of this process. Why was it that from 1767 the licentiates put forward demands for the reform of the College? After all, as Lord Mansfield pointed out, the distinction between fellows and licentiates had been known for upwards of a hundred years. Why then should this distinction, and the privileges associated with it, suddenly become unacceptable? Sir George Clark has suggested that one causally important factor in the development of the struggle was the changing numerical ratio between licentiates and fellows. He argues that ‘the numbers of the two grades in the College did not fit in at all conveniently with the distinction of status. If the licentiates had been the rank and file of the profession in London and the fellows a small minority it would have been easier to justify the distinction; but for a long time past there had been fewer licentiates than fellows. In 1708 there were . . . sixty-seven in the upper rank, against thirty-nine licentiates. This disparity was growing worse. In 1746 there were fifty-four fellows and twenty-four licentiates.’\[23\] An examination of the numbers of the College, however, would not seem to support Clark’s argument. Throughout the first half of the eighteenth century, there were more fellows than licentiates. However, the first year in which the licentiates outnumbered fellows—by 63 to 46—was 1765, just two years before the ‘battle of Warwick Lane’, and the licentiates continued to outnumber fellows from 1765 onwards.\[24\] Thus far from

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\[22\] Clark, op. cit., vol. II, p. 566.
\[21\] Stevenson, op. cit., pp. 118–19.
\[23\] Quoted in Stevenson, op. cit., p. 120. These motions were passed in October 1784, but not inserted in the minutes or confirmed until 1786.

The numbers of the College are given in Clark, op. cit., vol. II, Appendix II, pp. 736–39.
being accentuated, the traditional numerical ratio between licentiates and fellows was in fact reversed in the years immediately prior to and during the period when the struggle for reform was most intense.

It is unfortunately the case that while the literature contains many descriptions of the conflict between the licentiates and fellows, no adequate analysis of the social basis of this conflict has yet been put forward. A number of writers have however suggested that the development of the conflict was related in some way to the increased number of graduates of Scottish universities who became licentiates. Thus Miss Franklin has written that 'the struggle of the Licentiates against the Fellows reflected the difference in outlook between the more progressive scientific approach to medicine in the Scottish universities and the traditional classical approach of the English' while Sir George Clark has suggested that many licentiates were 'bound together by their Scottish education and several of them also had another link in not being members of the Church of England.' It is the view of the present writer, however, that no analysis has yet brought out the real significance of the Scottish graduates, and since it will be argued that this group provides a major clue to an understanding of the struggle for reform of the College of Physicians, it is necessary to look at this group in some detail.

### Intake of Licentiates According to Qualification, 1726-1775.

(Table compiled from Munk's Roll, Vol. II and the Dictionary of National Biography.)

<table>
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<tr>
<th></th>
<th>Edinburgh</th>
<th>Aberdeen</th>
<th>Glasgow</th>
<th>St. Andrew's</th>
<th>Oxbridge</th>
<th>Foreign</th>
<th>Unknown</th>
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<td>1</td>
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<td>1731-35</td>
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<td>1736-40</td>
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<td>1746-50</td>
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Throughout the whole of the first half of the eighteenth century, only seven Scottish graduates were admitted as licentiates of the College. The largest intake in this period was from graduates of foreign universities, thirty of whom were granted licences to practise. Licences were also granted to nineteen persons who had no medical degree, and to three persons who held a qualification from Cambridge. From about the middle of the century, however, the pattern of recruitment changed

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18 Franklin, op. cit., p. 1.
20 The term 'Scottish graduates' is used throughout to refer to graduates of Scottish universities; it does not imply that the graduates themselves were necessarily Scottish, and many of them, in fact, came from England.
21 This figure, and all the following figures relating to the licentiates have been calculated from Munk's Roll, vol. II.
22 That these three Cambridge graduates were not admitted to the fellowship is explained by the fact that two of them held only the M.B. degree, while the third was an alien. The three physicians involved were Thomas Dover, Musshey Teale, and John Scheuchzer (see Munk's Roll, vol. II, pp. 79-81, 82-83, 91-92).
quite markedly. The numbers of graduates of foreign universities who were admitted increased slightly, while the intake of those holding a degree from the English universities remained at a minimum. The number of persons who were admitted with no medical degree had been falling since the beginning of the century, and continued to decline after 1750. The major change, however, concerned the intake of Scottish graduates. In the quinquennium 1741–5, two Scottish graduates were admitted; in 1746–50 only one. From 1750 the numbers increased rapidly. In the period 1751–5, seven were admitted, in 1756–60, eleven, and in 1761–5, no less than twenty-five. The changing pattern of recruitment is clearly illustrated in the following table, which gives a complete breakdown of admissions, by education, in the fifty year period 1726–75.

These figures reflect quite clearly the rise of the Scottish medical schools in the eighteenth century, of which more will be said later, and indicate that in the years immediately preceding the conflict between the licentiates and fellows, a rapidly increasing number of Scottish graduates were admitted as licentiates. It is perhaps important to add, since the above table does not give figures for individual years, that of the twenty-five Scottish graduates admitted between 1761–65, seventeen were admitted in 1765, just two years before the conflict in the College flared up. Moreover, there is some evidence to suggest that the Scottish graduates played an active part in the struggle of the licentiates. Thus the first meeting of the Society of Collegiate Physicians was attended by thirty-one licentiates, of whom twenty-one were Scottish graduates. At this meeting, a president, a treasurer, two stewards and a secretary were elected; four of the five offices, including that of president, were filled by graduates of Scottish universities.®® The Scottish graduates were also well represented in the violent assault on the College in May 1767. Of the twenty-one licentiates who took part, fourteen were graduates of Scottish universities, and at least one other had attended courses at Edinburgh. The strength of the Scottish-educated contingent is also indicated in contemporary illustrations of the siege of the College. One of these shows the licentiates carrying two banners, one of which bears the inscription 'Pro Collegiis Scotiae', and the other 'Delenda Est Oxonia Delenda Est Cantabria'. In another illustration, the Scottish influence is clearly represented by the dress of the licentiates, while the fellows are pictured with words put into their mouths, indicating their anti-Scottish sentiments.®*

There is thus some evidence to indicate that the development of the conflict within the College of Physicians was related to the changing number of Scottish graduates who were admitted as licentiates, and that those who had received their professional education in Scotland were among the most militant of the licentiates. Now why did the Scottish graduates play such an active part in the struggle for the reform of the College of Physicians? Why were they so dissatisfied with the traditional structure of the College? In order to answer this, it is necessary to examine briefly the structure of medical practice in Scotland, and the development of the Scottish medical schools.

In Scotland, the separation between medicine and surgery had never been as rigid as it was in England. In Glasgow, practitioners of medicine and surgery had been

®® Stevenson, op. cit., p. 110.
®* Both illustrations are reproduced in Stevenson, op. cit.
united in the Faculty of Physicians and Surgeons since its foundation in 1599. Many practitioners had thus long united the practice of medicine with that of surgery, and this rapprochement between the different branches of practice was carried a step further with the development of the medical schools at Edinburgh and Glasgow. At Edinburgh, extra-mural teaching had been carried on, in one form or another, since the early sixteenth century, but it was not until 1726 that a medical faculty was established in the university. In 1720, Alexander Monro primus, who had been a favourite pupil of Boerhaave at Leyden, was appointed professor of anatomy, and he began teaching in the same year. Six years later, the Town Council, which had long been the governing body of the university, appointed Andrew Sinclair and John Rutherford as professors of the theory and practice of medicine, and Andrew Plummer and John Innes as professors of medicine and chemistry. They were given 'full power . . . to profess and teach Medicine in all its branches—to examine candidates, and to do every other thing requisite and necessary to the graduation of doctors of medicine.' From this time onwards, all the professors delivered regular and systematic courses of instruction. Monro taught anatomy and surgery, while Innes taught the practice of physic conjointly with Rutherford. Plummer lectured on chemistry as applied to pharmacy, and Sinclair took the institutes of theory of medicine as his province, using Boerhaave's *Institutiones Medicae* as his text book.

In 1726 the Town Council also created a chair of midwifery, not, however, for the university, but for the city. Thus the first holder of the chair, Joseph Gibson, was not a member of the medical faculty in the university. On the death of Gibson in 1739 however, his successor, Robert Smith, was appointed professor of midwifery in the university, 'with the same privileges and immunities' as the other professors. One other chair was created within the faculty in the first half of the eighteenth century, that of medicine and botany, in 1738. Charles Alston was appointed to the chair, and he delivered two courses of lectures annually for the next twenty-two years—one on botany and one on materia medica.

Medical students at the university were given clinical instruction from 1729, when a small infirmary was opened in the city. By the following year this instruction had proved so popular that the managers of the hospital drew up rules governing the conduct of clinical instruction and introduced a fee for 'walking the wards'. Soon, however, the facilities at the hospital proved inadequate, and a new, much larger hospital, designated by Royal Charter as the Royal Infirmary, was opened in 1741.

Edinburgh quickly gained an excellent reputation for the quality of its teaching, and by the middle of the eighteenth century it was rivalling Leyden for the position of Europe's leading medical school. Edinburgh, however, did not simply offer a
good medical education: it offered a medical education of a type quite new in Britain, involving the integration of a wide range of medical and allied subjects. By 1739, students at Edinburgh were given instruction not only in all the main branches of medicine, but also in anatomy and surgery, botany, chemistry as applied to pharmacy, and midwifery. Nothing like such a comprehensive education was available in England, where the education and examination of intending practitioners continued to be organized in terms of the traditional tripartite structure of the profession.

Thus in England the education of physicians was quite different from that of surgeons and apothecaries. The English universities aimed to produce cultured physicians, and it was not expected that such gentlemen, educated in the classics, would have much knowledge of the manual skills involved in such things as surgery, midwifery or the preparation of drugs. The examination for the licence of the College of Physicians involved only a narrow range of subjects, the College declining to examine in those branches of practice traditionally held to be outside the province of the physician.®® Surgeons and apothecaries, as befitted those who practised a craft or trade, usually received their training by apprenticeship. Like physicians, however, neither surgeons nor apothecaries were required to undergo an examination in all branches of practice. Thus candidates for the diploma of the Company of Surgeons were not examined in medicine or pharmacy, while surgery was not included in the examination of the Society of Apothecaries.

The development of the Edinburgh medical school was thus of considerable importance, for by integrating the teaching of medicine, surgery, and allied subjects, Edinburgh became the first medical school in Britain to provide an education designed to fit medical students to become general practitioners.

The medical school at Glasgow University developed a little later than that at Edinburgh. In 1742 Robert Hamilton was appointed to the chair of anatomy, and he appears to have taught the subject quite creditably. Four years later, William Cullen, after a short period as a private teacher, began lecturing on medicine within the university, and in 1748 he added lectures on materia medica and botany. He was appointed to the chair of medicine in 1750, about which time John Carrick, who had formerly aided Cullen in his courses on botany and materia medica, began lecturing on chemistry. Surgery was taught by the professor of anatomy, and he appears to have taught the subject quite creditably. Four years later, William Cullen, after a short period as a private teacher, began lecturing on medicine within the university, and in 1748 he added lectures on materia medica and botany. He was appointed to the chair of medicine in 1750, about which time John Carrick, who had formerly aided Cullen in his courses on botany and materia medica, began lecturing on chemistry. Surgery was taught by the professor of anatomy, as it continued to be until 1815. At the Glasgow medical school, as at that of Edinburgh, no rigid distinctions were drawn between different branches of practice, and by the middle of the eighteenth century, students at Glasgow were given instruction in both medicine and surgery, and in those subjects which formed the basis of pharmacy.®® Thus Glasgow, like Edinburgh, offered what was essentially an education for general practice.

In addition to Edinburgh and Glasgow, three other bodies in Scotland awarded degrees in medicine—the University of St. Andrews, and the two colleges in Aberdeen, King’s and Marischal. At none of these institutions, however, was there any systematic teaching of medicine in the eighteenth century, and all three conferred degrees

®® As late as 1834, surgery and midwifery were still excluded from the examinations of the College. See the Select Committee on Medical Education, 1834, 602-1, part 1, Q.2025-2027, 2568.

®® For the early development of the Glasgow medical school, see James Coutts, A History of the University of Glasgow, Glasgow, 1909, pp. 476-512.
without requiring any residence, without requiring candidates to have undergone any particular course of study, and, not infrequently, without even subjecting candidates to an examination. At St. Andrews, medical degrees were often conferred in absentia, in return for payment, the fee in 1747 being £10, of which the professor of medicine received £3. The ease with which medical degrees could be obtained from these institutions was satirized in Samuel Foote's play 'The Devil Upon Two Sticks'. Last, one of the characters in the play, explains that he has been in practice, without a licence, for about twelve years, but that now Lotion, a local apothecary who has 'grown old and lascivious' threatens to report him if he continues to practise without a qualification. Last goes on to say that 'I was telling my tale to Sawney McGregor, who comes now and then to our town with his pack; God, he advised me to get a licence at once, and send for a diploma from Scotland.' In spite of the lax manner in which degrees were granted, however, there is little reason to believe that graduates of St. Andrews or of either of the Aberdeen colleges were generally ignorant of their profession. In 1774, in a letter to William Cullen, who was then President of the Royal College of Physicians of Edinburgh, Adam Smith outlined his views on the conditions of graduation at Aberdeen and St. Andrews. While he criticized these institutions for taking part in what he called 'a most disgraceful trade' in degrees, Smith held that this practice rarely resulted in harm to the public. The title of Doctor, he held, 'is not so very imposing, and it very seldom happens that a man trusts his health to another merely because that other is a doctor. The person so trusted has almost always either some knowledge or some craft which would procure him nearly the same trust, though he was not decorated with any such title. In fact, the persons who apply for degrees in the irregular manner complained of, are, the greater part of them, surgeons or apothecaries, who are in the custom of advising and prescribing, that is, of practising as physicians; but who, being only surgeons and apothecaries, are not feed as physicians. It is not so much to extend their practice as to increase their fees that they are desirous of being made doctors.'

Smith thus suggests that many of those who graduated from St. Andrews and Aberdeen were either apothecaries or surgeons who were practising generally. This is very probable; an examination of Munk's Roll indicates that it was quite common for practitioners who were educated as surgeons and/or apothecaries, and who practised as such, to obtain a medical degree from one or other of these institutions. Thus Munk tells us that Joseph Allen was 'bred a surgeon' in which capacity he accompanied Lord Anson on his voyage around the world. He obtained a medical

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46 The letter, dated 20 September 1774, is to be found in The Wealth of Nations, ed. by J. R. McCulloch, 1838, note XX, pp. 382-85. Comrie has noted that at Marischal College, Aberdeen, 'for many years those who graduated appear to have been men who had already been for a considerable time in practice or who had published works on medicine', while at King's College, degrees in medicine were conferred 'not because of examinations which the student had successfully passed, but as a recognition by the university of general and professional attainments, however acquired.' He cites as an example of the manner in which degrees were given for purely honorary reasons and in absentia, the case of Patrick Blair, an apothecary in Cupar, who graduated M.D. from King's College in 1712 after being recommended by the Bishop of Aberdeen and several eminent physicians in Angus (Comrie, op. cit., vol. I, pp. 369-70). This is in accordance with Smith's observations.
degree from St. Andrews in 1754. John Fordyce, who practised for several years as a surgeon-apothecary at Uppingham, obtained a medical degree from Marischal College in 1756. Edward Spry served a five-year apprenticeship to a practitioner in Plymouth, and after continuing his education in London and on the continent, he returned to Plymouth and commenced practice as a surgeon. He was created Doctor of Medicine by the University of Aberdeen in 1759. The career of Thomas Denman was a little more varied. He was the second son of an apothecary, and on the death of his father he assisted his elder brother, who succeeded to the business. After attending classes in London he was appointed as a surgeon's mate in the navy, and in 1757 he was made surgeon. He left the service in 1763 and attended Dr. Smellie's lectures on midwifery, and the following year was created Doctor of Medicine by Aberdeen University. He subsequently became surgeon to one of the royal yachts, and developed a lucrative practice as an accoucheur. Other examples may be readily found in the pages of Munk's Roll.

It should be pointed out, however, that the granting of medical degrees to persons who had been in practice as surgeons or apothecaries was not confined to St. Andrews and Aberdeen, for it was also quite common at Edinburgh and Glasgow. Thus all the Scottish universities included among their graduates a considerable number of persons who had had experience in one or other of the lower branches of the profession. From this it may be argued that the Scottish universities functioned as important channels of social mobility, by providing many surgeons and apothecaries with the opportunity of improving the status of their practices, and, as Smith noted, of raising their fees.

It is significant that while it was common for surgeons or apothecaries to obtain a degree from one of the Scottish universities, this was virtually unknown at Oxford and Cambridge; almost invariably, graduates of the latter began their professional careers as physicians. Thus the career structure of many Scottish graduates was quite different from that of physicians educated at the English universities.

The preceding analysis is of some importance for an understanding of the struggle for the reform of the College of Physicians, for as we have seen, in the years immediately prior to the attempts to reform the College, there was a rapid increase in the number of Scottish graduates who became licentiates; we have also seen that the Scottish graduates played a very active part in the struggle for reform. Why, then, was the influx of Scottish graduates so significant? In the analysis so far it has been argued that the structure of medical practice and medical education in Scotland had

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48 See, for example, the biographical sketches in Munk's Roll of William Baylies, Thomas Dimsdale, Michael Underwood, and William Rowsley (vol. II, pp. 232-33, 271, 326-27, 340). A more famous example is that of Tobias Smollett, the novelist, who graduated M.D. from Marischal College, Aberdeen, in 1759; prior to this he had been a surgeon's mate in the navy, and in 1744 had commenced practice as a surgeon from a house in Downing Street. See David Hannay, Life of Tobias George Smollett, London, 1887, pp. 28, 42, 111.
49 Lester King has noted that many Scottish graduates had taken 'a certain amount of apprenticeship with an apothecary or surgeon', and adds, also in relation to the Scottish universities, that many individuals 'started their professional careers as apothecaries but finally achieved a doctor's degree'. See L. S. King, The Medical World of the Eighteenth Century, Chicago, 1958, pp. 27-28.
certain distinctive features. Firstly, it was pointed out that in Scotland the general practitioner had long been the rule. Secondly, it was argued that the two universities which offered any systematic instruction in medicine, namely Edinburgh and Glasgow, both aimed at integrating all the major branches of practice, and thus offered what was essentially an education for general practice. Finally, it was pointed out that all the Scottish universities frequently granted medical degrees to persons who had been in practice as surgeons or apothecaries. It is suggested that, with their distinctive educational and professional experiences, Scottish graduates would be much less likely to confine their practice to pure medicine than would those who had received their professional education outside Scotland.

The examination of the structure of medical education and medical practice in Scotland suggests therefore, the probability that many of the Scottish-educated licentiates did not practise as pure physicians. More direct evidence to support this suggestion may be found in Munk’s biographical sketches of many of those who took a leading part in the struggle for reform. Perhaps the most famous of the rebel licentiates was William Hunter, who was one of the stewards of the Society of Collegiate Physicians. Hunter received his early medical education from Dr. Cullen, with whom he resided at Hamilton for three years, and in 1741 came to London, where he lived with Mr. (later Dr.) Smellie, at that time an apothecary in Pall Mall. Later he entered as a surgeon’s pupil at St. George’s Hospital, and in 1747 obtained the diploma of the Corporation of Surgeons. Hunter practised both surgery and midwifery, but had a marked preference for the latter. He graduated from Glasgow in 1750, but his major interests remained in the fields of anatomy and obstetrics, and throughout the third quarter of the eighteenth century he was the most eminent accoucheur in London.®

Many of the other Scottish graduates who were active in the struggle for the reform of the College had, like Hunter, been educated as surgeons or apothecaries. Thus Maxwell Garnshore served an apprenticeship to a surgeon-apothecary in Edinburgh, on completion of which he became a surgeon’s mate in the army. In 1756 he settled at Uppingham, taking over the lucrative practice which John Fordyce had built up as a surgeon-apothecary, and which the latter relinquished on moving to London. In 1764, Garnshore graduated from Edinburgh and, moving to London, was admitted a licentiate of the College in the same year. In London he practised chiefly as an accoucheur.® John Fothergill, the other steward of the Society of Collegiate Physicians, was ‘bred an apothecary’ and served an apprenticeship to Benjamin Bartlett, an apothecary at Bradfield in Yorkshire.® Luke Wayman was also ‘bred an apothecary’, in which capacity he practised at Royston for several years,® while John Elliot began his medical career as an apothecary’s assistant, and later went to sea as a surgeon.®

An examination of Munk’s Roll and the Dictionary of National Biography indicates

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® Munk’s Roll, vol. II, p. 239. See also Gentleman’s Magazine, 1812, 387-91.
®® Ibid., vol. II, p. 239.
that, of the twenty-one Scottish graduates who attended the first meeting of the Society of Collegiate Physicians, no less than nine had been educated as surgeons or apothecaries, while a tenth, Hugh Smith, was the son of a surgeon-apothecary, and probably received some instruction from his father. In fact, however, the number of Scottish graduates who were trained as surgeons or apothecaries may well have been higher. The main source for biographies of the licentiates is Munk's Roll, and it is clear that this information is far from complete. Thus Munk indicates that Alexander Russell 'studied medicine under his uncle, an eminent practitioner in Edinburgh'; he does not indicate, however, that the uncle in question was a surgeon. Similarly, in his note on John Hill, Munk does not indicate that Hill began his medical career as an apothecary. In the cases of Russell and Hill, fuller details of their careers were obtained by cross-checking Munk's biographies with those in the Dictionary of National Biography. Since, however, many of the licentiates who took part in the struggle for reform are not listed in the latter, it has not always been possible to check Munk's information.

In addition to these Scottish graduates who had been educated as surgeons or apothecaries, a number are known to have practised midwifery. Indeed, it would seem that this practice was common among Scottish graduates, as indicated by William Hunter's famous toast 'May no English nobleman venture out of the world without a Scottish physician, as I am sure there are none who venture in.'

To summarize, of the Scottish graduates who were active in the Society of Collegiate Physicians, something like a half had received their professional training at Edinburgh, probably the finest school for general practitioners in Europe. Just under a half had originally been trained as surgeons or apothecaries, and, in addition, there is some reason to believe that the practice of midwifery was common among Scottish graduates. All this tends to support the suggestion that many Scottish graduates did not practise as pure physicians. This is of major importance, for the struggle to reform the College of Physicians has traditionally been regarded as a conflict between two groups of physicians, the fellows and the licentiates. It is suggested here, however, that the structural basis of the conflict lay in the fact that the Scottish graduates did not practise as physicians, but as general practitioners. In order to understand this fully, we have to examine briefly the structure of the College of Physicians, and the policies pursued by the College.

Traditionally, the physician was, as we have seen, a cultured gentleman, learned in the classics. He was not expected to have much knowledge of the manual skills involved in the work of the surgeon or apothecary and indeed, as is common among privileged status groups, such work was shunned as degrading. The prejudice against manual work was, in fact, the central aspect of a complex ethos which...
Physicians had developed a legitimation of their dominant position within the profession, and of their high status within the wider community. Another important aspect of this ethos involved the rejection of participation in any overtly economic activities. As Max Weber has pointed out, 'the notion of honour peculiar to status absolutely abhors that which is essential to the market: haggling. . . . Therefore, everywhere some status groups, and usually the most influential, consider almost any kind of overt participation in economic acquisition as absolutely stigmatizing.'

Within the medical profession there was, on this point, a clear contrast, enshrined in law, between physicians on the one hand, and surgeons and apothecaries on the other. Thus while surgeons and apothecaries could sue a patient for recovery of charges, physicians were unable, prior to the Medical Act of 1858, to bring such an action. As befitted gentlemen, physicians were considered, so far as the law was concerned, as attending patients for an honorarium, and as such, they were unable to maintain an action for fees.

In order to maintain the high status which physicians had long enjoyed, the College of Physicians persistently attempted to maintain the barrier between the physician and the 'lower orders' of surgeons and apothecaries, who were regarded as craftsmen or traders rather than gentlemen. Thus, as we have seen, the College refused to examine candidates for its licence in any branches of practice traditionally held to be outside the sphere of the physician. Moreover, the College, like the Company of Surgeons, who were equally keen to draw a sharp line between themselves and the mere apothecaries, excluded from its governing Council those who practised as apothecaries, and those who practised midwifery. The means by which the two corporations had effected this policy were however different. In the Company of Surgeons, a bye-law of 7 April 1748 expressly stated that no persons following 'any other trade or occupation besides the profession or business of a surgeon' could be chosen into the Court of Assistants (Council). In the College of Physicians, however, the policy of excluding from the Council those who worked with their hands had, for a long time, been achieved by restricting the fellowship of the College to graduates of Oxford or Cambridge, that is, to gentlemen by whom the manual work involved
in pharmacy or midwifery was seen as degrading. When, however, the influx of a large number of Scottish-educated general practitioners posed a major threat to the traditional ideal of the gentleman-physician, the College quickly responded by making the ban on the practice of midwifery and pharmacy explicit. Thus in 1771, new byelaws were passed which stated that no person practising midwifery was to be admitted to the fellowship, that physicians practising as apothecaries were not to be admitted, and that fellows who entered on practice as apothecaries were to be expelled.60 Thereafter the College fought a long battle against the rise of the general practitioner, and the dilution of the gentleman-physician ideal which this implied. In 1795 the College approved the refusal of the President, Sir George Baker, to examine an apothecary who applied for a licence to practise as a physician, and instructed the officers of the College to prepare a statute authorizing the like rejection of any person employed as an apothecary or surgeon.61 In the 1820s, after a suggestion that the College should examine in midwifery, a committee reported to the College, giving a plethora of historical information, tending to show that ‘the object of the College has been to confine the fellows to the pure practice of physic’.62 In 1834, it was still necessary for an apothecary or surgeon to be disfranchised from the Society of Apothecaries or the College of Surgeons before applying for a licence from the College of Physicians.63

It should be apparent that the Scottish-educated general practitioners did not fit in neatly with the traditional ideal of the gentleman-physician, and it is hardly surprising that they should be dissatisfied with a College which was dedicated to maintaining the separation between medicine and other branches of practice. It must be emphasized that the problem of the relationship between medicine, surgery, pharmacy, and midwifery was not simply an abstract debate about the nature of medicine as a body of knowledge, for, as has been pointed out, the whole problem was intimately bound up with questions of status, both within the professional community, and in the wider society. It would be very wrong, therefore, to regard the conflict between the licentiates and fellows as simply a conflict on the level of ideas about the relative merits or demerits of ‘scientific’ Scottish medicine as opposed to the more classically oriented English medicine, for there was a very real conflict of interests on a social structural level.

This conflict can perhaps best be understood in terms of Elias and Scotson’s conceptualization of ‘established’ and ‘outsider’ groups.64 The pure physicians constituted an old, established group par excellence. Long regarded as the dominant group within the profession, their position of dominance, and their high status in the wider society, rested essentially on their claim to be gentlemen. It was, however, precisely this claim which the Scottish-educated licentiates, by engaging in work normally performed by surgeons and apothecaries, threatened to undermine. The pure physicians feared that the influx of general practitioners would drag them down to a lower status level in their own estimation as well as in that of the profession and

60 Clark, op. cit., vol. II, p. 566.
61 Ibid., vol. II, p. 621.
63 Select Committee on Medical Education, 1834, (602-1), part 1, Q.1814 2739, 3464-3465.
the wider society. In the face of this threat, the fellows reacted in a manner typical of the way in which established groups generally react to such threats to their status. Thus, while they could not prevent the Scottish universities from producing large numbers of general practitioners, they could, and did, draw a sharp line between themselves and the general practitioners, relegating the latter to an unambiguously subordinate position within the profession. Thus not only was the licentiates' characteristic mode of earning a livelihood—general practice—clearly defined as a lower status occupation, but the general practitioners themselves were excluded from holding political offices within the College, first by the rule which restricted the fellowship to graduates of Oxford and Cambridge, and subsequently by the bye-laws of 1771.

Given this situation, it is hardly surprising that the Scottish graduates should be dissatisfied with the traditional structure of the College, for the Scottish-educated licentiates were, in effect, general practitioners within a College of Physicians whose policies were designed precisely to prevent the rise of the general practitioner. It should be emphasized that while the institutional structure of the profession was organized around the traditional structure of physicians, surgeons, and apothecaries, the general practitioner was neither physician, nor surgeon, nor apothecary; he was essentially a new type of practitioner, standing outside of this traditional structure. As such, there was no clearly defined position for him within this structure. Unwanted by all the medical corporations, the general practitioner was at best tolerated, never welcomed as a full member of the professional community.

The relationship between 'established' and 'outsider' groups, of which it is suggested that this is an example, has been summarized, in a different context, by Elias and Scotson as follows: 'The newcomers resent, and often try to rise from, the inferior status attributed to them and the established try to preserve their superior status which the newcomers appear to threaten. The newcomers cast in the role of outsiders are perceived by the established as people "who do not know their place"; they offend the sensibilities of the established by behaving in a manner which bears in their eyes clearly the stigma of social inferiority, and yet, in many cases, newcomer groups quite innocently are apt to behave, at least for a time, as if they were the equals of their new neighbours.' The basic problem which confronted the medical profession for over a hundred years from the mid-eighteenth century onwards, was of how to integrate this new type of practitioner, the general practitioner into an established institutional structure which had no place for him. It is suggested that the movement to reform the College of Physicians in the period 1767–71 can properly be seen as the first of a long series of movements by general practitioners to achieve a recognized and respectable position within the profession.

Perhaps it is necessary to point out that, while it is clear that most Scottish graduates were practising generally, it is not suggested that, as yet, they had any clear-cut conception of themselves as general practitioners. Rather, it would seem that they continued, at this stage, to see themselves as physicians; that this was so is indicated by the nature of their demands. Thus what the licentiates demanded was essentially recognition of their status, not as general practitioners, but as full members of the professional community.

68 Ibid., p. 158.
Colleges of Physicians. In medicine, as in other fields, changes in terminology and in men's self-conceptions occurred somewhat more slowly than changes in the actual structure of the profession. Thus whereas the general practitioner emerged in the eighteenth century, the term 'general practitioner' did not emerge until the early nineteenth century. The development of what may be called 'general practitioner consciousness' was thus a product of the nineteenth, rather than of the eighteenth century.

It has been suggested that the most important causal factor in the development of the reform movement within the College of Physicians was the emergence of a new type of medical practitioner alongside an established institutional structure which had no place for him. Nevertheless, in seeking for an adequate analysis of this movement, it would be wrong to ignore completely changes occurring outside the profession. In particular this movement may be related to changes in the structure of political activity on a national level.

The period from 1760 onwards was one of considerable dissatisfaction with the structure of English politics. The parliamentary system came to be increasingly criticized, both for its widespread corruption, and for its unrepresentative character. As E. Neville Williams has pointed out, 'the whole eighteenth century system was subjected to searching criticism, not merely of its practical working but even of its theoretical foundations.' The extent of the discontent with the political system is indicated not only by the 'Wilkes and Liberty' movement of 1768–69, but also by the development of a number of other reform movements, including the Society of Supporters of the Bill of Rights, founded by Wilkes' ally, 'Parson' John Horne, and by the widespread circulation of a number of radical political tracts. In 1772–3, James Burgh in his enormously popular Political Disquisitions, demanded universal male suffrage, a principle which Wilkes introduced into his measure for parliamentary reform, rejected by the Commons in 1776. That year also saw the publication of Major Cartwright's Take Your Choice! and of Richard Price's On Civil Liberty, the latter of which sold 60,000 copies immediately and double that number in a cheaper edition.

It is not the task of this paper to examine this movement in any detail. It is, however, important to note the similarity between the objectives of the licentiates of the College of Physicians, and of those demanding political reforms on a national level. In a long-term perspective, the significance of this wider reform movement of the eighteenth century lies in the important part which it played in the extension to all members of the community of what T. H. Marshall has called citizenship rights. The claim to be admitted to citizenship is, as Marshall has pointed out, 'a claim to be admitted to a share in the social heritage, which in turn means a claim to be accepted as full members of the society'. The notion of citizenship involves, above all else, the idea

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that there is 'a kind of basic human equality associated with the concept of full membership of a community'. It was this basic aim—full membership of their respective communities—which the licentiates shared with the radicals in the wider society, for essentially the licentiates were demanding full membership of their professional community, just as the radicals demanded full membership of the political community.

Finally, one other important similarity between these movements should be brought out. As Professor Rude has pointed out, pre-industrial popular movements had certain distinctive characteristics which enables them to be differentiated from the earlier popular movements of the medieval period on the one hand, and from the later 'industrial' movements on the other. It is significant that the movement to reform the College of Physicians, like other popular protest movements of the period, was in many respects characteristically pre-industrial in form. This is particularly true of the licentiates' violent assault on the College in 1767, which exhibited many of the structural characteristics typical of what Rude has called the 'pre-industrial' crowd'. Those aspects of the violent assault on the College which mark it as a 'pre-industrial' form of protest include what Rude terms its 'form of action', its 'spontaneity' and lack of organization, and, on the level of ideology, its concern for tradition and for the restoration of 'lost' rights. The 'forms of action' typical of the 'pre-industrial crowd' were predominantly of the 'direct-action' type. The prevailing form of protest was one of violence applied to property, but not to life and limb.

In the assault on the College on 24 September 1767, the licentiates broke forty windows and smashed three doors. The tactics were clearly those of the eighteenth-century 'mob', even though the participants were of a higher social status. The 'spontaneity' and lack of organization is also indicated by the events of 24 September and 30 September 1767, for on both occasions the plan to assault the College was probably conceived immediately beforehand in the tavern in St. Paul's Churchyard. A particularly clear indication of the spontaneity of these tactics is to be seen in the licentiates' failure, on 30 September, to engage a blacksmith, whom they needed to break open the College gates. Clearly no blacksmith had been hired in advance, and when the licentiates failed to hire one in the tavern, they had to change their plan of action.

Of even greater importance, however, was the licentiates' concern with tradition and with the restoration of 'lost' rights, for this characterized the whole movement from 1767–1771. Their campaign, in fact, revolved around the idea that at some point in the development of the College, the fellows had illegally usurped the control of the College, thus deviating from the College's assumed original egalitarian structure. In addition, as we have seen, the licentiates conceived of themselves not in their new role of general practitioners, but in the traditional role of physicians. As such, their campaign was essentially backward-looking and conservative, for what the general practitioner licentiates were demanding was, in effect, assimilation into the traditional institutional structure of the profession. The general practitioner, however, by the

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70 Ibid., p. 72.
72 Ibid., pp. 19–23.
very nature of his type of practice, cut across all the traditional professional boundaries in terms of which this institutional structure had been established, and there could, therefore, be no possibility of general practitioners achieving a recognized position within the profession as long as this traditional institutional structure remained unchanged. The future of the general practitioner was to lie not in backward-looking aims, such as those which characterized the licentiates' movement, but in the development of new institutions which more adequately represented his interests, and, eventually, in the abolition of the traditional tripartite structure of the profession.

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The Role of the Hospital in the Development of Modern Medicine: A Sociological Analysis

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Abstract  Basic and far-reaching innovations in the structure of medical knowledge were made in Paris in the early part of the nineteenth century. In order to explore the social basis of these innovations, attention is focused on the development of hospitals in Paris, and the way in which this development was associated with the emergence of the doctor as the dominant figure in the doctor-patient relationship. This type of relationship is contrasted with the structure of practitioner-client relationships in the eighteenth century, which were characterized by a structure of client control. Some of the ways in which the dominance of the doctor within the hospital situation facilitated innovation in medical knowledge are examined.

The advent of modern medicine has been ascribed to a variety of times and places, but a good case has been made out for the suggestion that the foundations of modern medicine were laid in Paris in the early part of the nineteenth century, for it was here that the concept of a localized pathology, based on the techniques of physical examination and autopsy, was introduced. A number of eminent medical historians have pointed to some of the social structural changes which were conducive to the emergence of modern medicine in Paris. Among the more important of these changes may be noted the compulsory closure, during the revolutionary period, and the subsequent reorganization, of the institutions of medical education, the effects of war, the breakdown of the rigid distinctions between physicians and surgeons, and the development of the hospital system in Paris. In this paper, which constitutes part of a more general study of medicine in early nineteenth century Paris, attention will be focused on the last mentioned process—the development of the Paris hospital system—and the ways in which this development facilitated what proved to be basic and far-reaching innovations in the corpus of medical knowledge. Although some medical historians have pointed out that hospitals did play a significant role in the development of modern medicine, it is suggested that the reasons for this significance have not been fully understood.

The suggestion that the Paris hospitals played a strategic role in the development of modern medical science has, perhaps, been most forcefully argued by Erwin Ackerman-h, who has aptly characterized early nineteenth century French medicine as 'hospital medicine', thus differentiating it from the preceding 'library' and...

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'bedside' medicine, and from the subsequent 'laboratory medicine'.^ Ackernknecht cites a contemporary observer to the effect that 'It is generally recognized that the true advances which medicine has made lately must almost all be attributed to those doctors who practice or observe in the hospital', and he goes on to suggest that 'it was only in the hospital that the three pillars of the new medicine—physical examination, autopsy, and statistics—could be developed'.

It is difficult to quarrel with the emphasis which Ackernknecht and others have placed on the development of hospitals. From 1794, the Paris hospitals were state owned and, from 1801, strongly centralized under the Conseil Générale d'Administration. This centralized ownership and control of hospitals made possible a much more rapid expansion, both in terms of the number of hospitals, and of their size, than was possible in a situation where hospitals were privately financed and controlled by charitable institutions, as in England. This expansion of hospital facilities in Paris, which appears to have been part of a more general—and very modern—plan to expand all health and welfare facilities for the poor,^ greatly impressed foreign observers^ and provided clinicians with the opportunity of seeing far more patients than had formerly been possible in private practice.

It is difficult to get precise statistical information on the expansion of the Paris hospitals, since different observers selected their material according to different criteria. Yet some idea of this expansion may be gained from the following figures. According to Bouchardat, Paris hospitals received 37,743 patients in 1807, 41,000 in 1817, and 53,000 in 1827.^ In 1843, an American observer, F. Campbell Stewart, calculated that in 1840 the general and special hospitals had received no less than 83,643 patients, while an additional 20,624 had been received into hospices and houses of refuge. International comparisons are bound to be imprecise; but in 1823, in what was probably an underestimate since he leaves out certain categories, Caspar mentions twelve hospitals and twelve hospices in Paris with a total of 15,000 inmates. In contrast, Abel-Smith has estimated that in 1800 there were about 3,000 patients in British hospitals, and as late as 1851, when the importance of hospitals was first recognized by a special category in the census of population, only 7,619 hospital patients were enumerated.^ It is clear that the Paris hospitals provided much greater opportunities for research than had ever before existed; J. B. Bouillaud saw no less than 25,000 cases in a three-year period,^ an achievement which would have staggered the great eighteenth-century Dutch clinician Boerhaave, who had only twelve beds in his teaching wards.

The significance of the development of hospitals, however, went far beyond the fact that they enabled doctors to see a far greater number of patients than was possible in private practice. Equally important—and this is a point which has escaped the notice of medical historians—was the fact that it was within the hospital setting that a new type of doctor-patient relationship emerged. To understand this point more fully, we shall have to examine the structure of this relationship in the eighteenth century.
Holloway has pointed out that in the eighteenth century, the aristocratic and wealthy patient was the dominant figure in the doctor-patient relationship; that is, the relationship was one of patronage. By virtue of the wider social bases of his power, the client was in a position to define both his own needs, and the manner in which those needs were to be met. Thus 'the patient, not the doctor, determined the conditions on which service was rendered. The client demanded a cure; the practitioner was in no position to suspend judgement and proceed with caution. He had to act quickly; treatment had to be given and conclusions drawn from partial evidence or even from pure speculation'. Thus the doctor, 'faced by powerful, wealthy, critical, demanding, and ill-informed patients, was forced into the role of lackey and mere comforter'. This aspect of the patronage system was nicely satirized towards the end of the seventeenth century by Molière in his Le Malade Imaginaire, in which Didaforus is asked whether he intends to procure for his son a position of physician at court. Didaforus replies 'To be quite frank I have never found the practice of our profession among people of great consequence very attractive. My experience has been that it's better for us to practice among the general public. They are less exacting. You don't have to answer to anybody for your actions and provided you keep to the beaten track of professional practice you don't have to worry what happens. The trouble about people of consequence is that when they're ill they absolutely insist on being cured'.

Under such conditions, client control was maximized, and the technically-based authority of the doctor minimized; indeed, technical competence was not the major criterion in terms of which practitioners were evaluated. The eighteenth century physician was expected to be, above all else, a gentleman, socially accepted in the circles among which his patrons moved. Elegance and wit were of greater importance than technical competence.

It is clear that such a situation was inimical to basic research and innovation in medicine. In the first place, since practitioners were not evaluated primarily in terms of their technical competence there was little incentive to engage in research. Medical careers in the eighteenth century were furthered not so much by making basic discoveries, as by making new friends in the appropriate social circles. In the second place, research is almost inevitably a lengthy process requiring the researcher to 'suspend judgement' and 'proceed with caution'. Yet this was precisely what the eighteenth century physician, faced with the demands of his patron for a cure, could not do. Faced with this situation, most physicians tended to adhere to one or other of the monistic systems for which eighteenth century medicine is so famous, and which provided the practitioner with a cure for every conceivable illness which the patient might develop. Finally—and this constitutes perhaps the most serious obstacle to innovation—wealthy private patients were unlikely to be willing to act as guinea pigs for new, and perhaps uncomfortable and potentially dangerous techniques. Thus the patient had the final power of the veto.

The structure of the doctor-patient relationship which emerged in the Paris
hospitals was of a radically different kind, for it was in the hospitals that the doctor first emerged as the dominant partner in the relationship. This point, it is suggested, is of the utmost importance for an understanding of the development of modern medicine. In this context, it is important to analyse some of the characteristics of the new medicine which emerged at this time, and some of the problems to which it gave rise. Perhaps one of the most important methodological changes characteristic of early nineteenth century medicine was the shift from observation to examination; there is a good deal of truth in the oft-repeated phrase that prior to 1800 physicians observed their patients; subsequently they examined them. The new emphasis on physical examination was indicated not only by the work of Corvisart and Bayle on auscultation and Laënnec’s invention of the stethoscope in 1819, but also by the renewed interest shown by French clinicians in the use of the clinical thermometer in the second quarter of the nineteenth century, and by the development of pulse counts from the 1840s. Subsequently, of course, a wide variety of instruments were invented for the examination of every accessible organ.

However, the shift from observation to examination—an essential characteristic, it has been suggested, of medicine in France in the early nineteenth century—was not unproblematic, for it gave rise to the critical problem of access, both to the patient’s body and to information which might be considered private. It has, unfortunately, been all too often assumed that developments in medicine can be explained without reference to the structure of the doctor-patient relationship; it is suggested, however, that the consent of patients to new and, perhaps, uncomfortable diagnostic procedures cannot be assumed but has to be explained.

Perhaps Parsons has done more than any other sociologist to emphasize this potential source of friction in the doctor-patient relationship. As he points out, the physician ‘deals with human beings, and does so in situations which often involve “intimacies”, that is, in contexts which are often considered peculiarly “private” to the individual himself, or to especially intimate relations with others’. Thus to see a person naked in a context where this is not usual, and to touch and manipulate their body is a ‘privilege’ which calls for explanation. To cite Parsons again, ‘it is clear . . . that both the parts of the body themselves, and acts of exposure and of bodily contact are expressive symbols of highly strategic significance’.

Yet in a situation where detailed examination is of major importance for diagnosis and treatment, it is essential for the physician to have access to the body of his patient. Here it should be noted that some of the doctor’s contacts, as in the case of a rectal or vaginal examination, would not normally be permitted to any other person, even perhaps to a sexual partner.

Related to this is the problem of sentiments toward ‘injury’ of the body, around which are centred many complex anxieties. Here we might note that in our own society many people have severe anxieties about such simple, routine, procedures as the insertion of a hyperdermic needle or the taking of a blood sample. Thus the
problem of securing the consent of the patient to certain types of diagnostic procedures, or to certain types of therapy, is not to be easily taken for granted.

In modern medical practice, these potential sources of tension are kept in check by the institutionalization of certain values surrounding the doctor’s role, which are learned by the medical student in the course of his professional education and enforced by the professional community. But in the early part of the nineteenth century professional codes were not highly elaborated and not rigidly enforced. Hence a crucial question has to be answered: why was it that there was no resistance from patients to a kind of medicine which might expose them to considerable physical and psychological discomfort, as well as to a good deal of inconvenience? Here it should be noted that the acceptance of modern medicine, as Parsons has pointed out, cannot be understood in terms of a simple process of weighing a rationally understood ‘need’ against an equally rationally assessed ‘cost’ in the form of discomfort or inconvenience, for very complex non- and irrational reactions are involved not only with the ‘abnormal’ but also with the typical patient.

Hence we return to our question: why was it that patients offered no resistance to the new medicine? In answering this question, the first point to be made is that patients were in no position to offer effective resistance; they had to take what was offered. The most cursory glance at the situation of doctors holding hospital appointments, and of that of their patients, reveals a marked difference in social status in favour of the doctors. Hospital consultants comprised the élite group of medical practitioners, for hospital positions were even more highly prized than positions in the university hierarchy.17 Not only did they have a virtual monopoly of research facilities, but their status within the hospitals enabled them to attract the wealthiest private patients.

In marked contrast was the situation of the hospital patient, who was not only sick, but generally poor too. Conditions in hospitals, and in particular the danger of cross-infection, were sufficient to repel all those who could afford treatment at home. In commenting on English hospitals at this period, Abel-Smith has observed that ‘Some of those who did not have fatal diseases when they entered hospital acquired them after admission’.10 The situation was no better in Paris. Thus Mac-Auliffe cites some contemporaneous (1793) observations to the effect that ‘Les hôpitaux étaient véritablement “...et entassement de malades qui les rendent souvent plus dangereuses que la maladie elle-même”’.19 It is worth recalling here Florence Nightingale’s famous statement that the ‘very first requirement in a hospital (is) that it should do the sick no harm’.20 Hospitals in the early nineteenth century failed to meet even this requirement. Tenon, writing in 1788, gives us this description of a major hospital in Paris: ‘The general policy of the Hôtel Dieu—policy caused by the lack of space—is to put as many beds as possible into one room and to put four, five or six people into one bed. We have seen the dead mixed with the living there. We have seen rooms so narrow that the air stagnates and is not renewed and that light...
enters only feebly and charged with vapours. We have seen convalescents together with the sick, the dying and the dead, forced to go barefoot to the bridge in summer and winter when they need fresh air. We have seen a room for convalescents on the third floor which could be reached only via the smallpox ward. The ward for the insane is next to the one for the unfortunate post-operative patients who cannot hope for rest in this neighbourhood which is full of outcries day and night'. Tenon concludes 'A thousand particular and accidental causes are added every day to the general and constant causes of air corruption, and force us to conclude that the Hôtel Dieu is the most unhealthy and most uncomfortable of all hospitals, and that of nine patients two die'. Indeed, conditions in hospitals were so bad that during the revolutionary period, reformers seriously recommended abolishing the hospitals, and replacing them with a more widespread system of domiciliary assistance for the sick poor. Although conditions improved somewhat after the revolutionary period—increasingly, for example, each patient came to have his or her own bed—nevertheless conditions in most hospitals remained grim. Thus Campbell Stewart calculated that the mortality rate at the Hôtel Dieu in 1816 was 1:4.57, almost exactly the same as Tenon's pre-revolutionary estimate. Conditions at other general hospitals were little better. Thus for the period 1805–1814, the mortality rate at the Hôpital Saint Antoine was 1:5.5, while that of the Hôpital de la Charité was 1:7. It is clear that hospitals were not places to which one went through choice. They housed those who could not afford to pay a medical practitioner and who had no domicile, or no kin to care for them in illness.

The relatively powerless position of hospital patients was nicely pointed up by some comments by Campbell Stewart, who wrote that the patients are 'always required to conduct themselves in an orderly and respectful manner; they are aware on entering a hospital that they must comply, unhesitatingly, with their advice, and abide by the directions of the medical officers; if the slightest difficulty occurs they are immediately discharged'. Even more revealing, perhaps, are his comments on the problem of securing the consent of patients to surgical operations which, it should be remembered, were at this time both extremely dangerous and, frequently, excruciatingly painful. 'It is', he wrote, 'always optional with them to submit to a proposed operation or decline it, but in cases where such operation is considered requisite, they must either submit or leave the hospital'. It is clear that in a situation where patients were not in a position to obtain medical care from an alternative source—that is, by employing a practitioner privately—they had, in effect, little option but to 'submit' to the therapies recommended by the hospital doctors. It might be added that even Campbell Stewart's choice of terms—notably his reference to patients 'submitting' to the prescribed therapy, nicely brings out the dominance of the doctor in the doctor-patient relationship. The contrast between the comparatively powerful position of the eighteenth century patron and the comparatively powerless position of the early nineteenth century hospital patient is so stark as to require no further comment.
Some further consequences of this new type of doctor-patient relationship should, however, be noted. One of the most important consequences was that the hospital patient, unlike the eighteenth century patron, was in a position to define neither his own requirements, nor the manner in which they were to be met. Perhaps for the first time, doctors were in a position to ignore the wishes of their patients in situations where to grant those wishes would run counter to their professional judgement. Thus doctors could now define the problems, and the manner in which those problems were to be solved, according to criteria established by the profession, not by the patient. The patient was no longer in a position to 'insist on being cured'; the doctor, however, was in a position to 'suspend judgement', to 'wait and see'. The doctor, in short, was no longer the 'lackey and mere comforter' of the rich. As a result, the emphasis in medical research was now able to move away from problems of therapy—which were of course, of prime interest to the patient—to the more basic problems of the diagnosis and classification of disease.

This shift of emphasis away from therapeutics was, indeed, so strong, that 'therapeutic nihilism' became almost a defining characteristic of medicine in France during the early nineteenth century. The extent to which therapeutic measures were ignored by French doctors during this period may be judged by the fact that Pinel's most eminent pupil, Bichat, left in print only six pages on therapeutics, in the 'General Considerations' of his General Anatomy, while G. L. Bayle claimed that pathology, 'cultivated in our days with such ardour, will keep away a lot of hypothetical indications and the hope of curing all diseases'. Laënnec, perhaps the outstanding figure in the medical revolution, held that 'Nature cures fevers better than art', while Andral reversed the classic saying 'Better something doubtful than nothing' to read 'Better nothing than something doubtful'. Laënnec was even accused by Broussais of being more interested in performing autopsies than he was in preventing them. Whatever the truth or otherwise behind this accusation, what is clear is that the medicine of 1850 had stopped short when confronted by the problems of therapy; as Shryock puts it, 'it seemed to have come to a dead end on the high road to human betterment'. In the long term, of course, the discoveries in basic research, particularly in anatomy and pathology, provided the groundwork for the development of a whole range of effective therapies; in the short term, however, 'it appeared only as if that little which the patient had, had been taken away'. Hence the paradox that the 'most hopeful period in the history of medicine was the one in which the public looked to medicine with the least hope'. If the therapeutically oriented medical systems of the eighteenth century were associated with a structure of client control, equally, it is suggested, the 'therapeutic nihilism', and the discoveries in the basic sciences in early nineteenth century France, were associated with the emergence of the medical practitioner as the dominant partner in the doctor-patient relationship.

Of course, it is not suggested that clinicians in Paris gave up treating patients
altogether; what was involved was a relative shift of emphasis away from problems of therapy to more basic research problems. Indeed, in relation to therapy, it should be remembered that, for a variety of reasons, the hospital provided the ideal structural situation for minimizing resistance to new forms of treatment. In private practice there remained not only the possibility of objection by the patient to the use of new forms of treatment, but also the fact that if the treatment was unsuccessful, the physician was likely to lose a wealthy client. In the hospital, not only were patients unlikely to object, but if an experiment failed, at least there would be no repercussions on the doctor’s private practice.

Consider, for example, the following description of an operation performed by Roux at the Hôpital de la Charité in 1828, and witnessed by a visiting American doctor, Peter Solomon Townsend. The operation was ‘upon one of the smaller intestines which opened by an artificial anus into the vagina’, and was performed upon a young woman of about twenty years of age. Townsend tells us that ‘Mr Roux now took the scalpel (the spectators at this time having increased to about 250 students and about 20 professional persons in the area) and having made an incision of about 3½ inches on the linea alba immediately above the pubis, soon reached the cavity of the abdomen but was not enabled until after some time (perhaps about ½ of an hour during which the patient necessarily suffered excruciating agonies) to detect, cut out and tie the diseased portion of the gut. During the whole of this difficult and appalling operation the surgeon manifested the greatest coolness and presence of mind’. Shortly afterwards the patient died. Subsequently, Townsend reports a conversation with Dumont, the son-in-law of Pariset, and a practising physician himself. Dumont deprecated ‘the bold experimental surgery of Roux who he said was guilty of murder in the operation I saw that gentleman perform some few weeks since . . . and that the young woman therefore enjoying the best of health (with an artificial or vaginal anus it is true) owed her death to the hands of the Surgeon’. Townsend himself, while admiring the ‘coolness and presence of mind’ of Roux during the operation, admitted that it ‘was indeed next to impossible she should survive where the peritoneum and cavity of the abdomen were for so long a time (an hour or more) exposed to the air and the hand and knife of the surgeon’. Dumont also criticized Lisfranc for an operation which he had performed, and which Townsend had witnessed, at the Hôpital de la Pitié. The operation carried out by Lisfranc was, said Dumont, a ‘barbarous experiment’, and he added that it was one of ‘many other bold and violent surgical operations now in vogue in Paris practised by certain men ad captandum and to obtain celebrity’. Dumont’s comments unambiguously draw attention to the highly vulnerable and potentially exploitable situation of hospital patients at this time. At the very least, it seems reasonable to suggest that doctors would not have been keen to risk the lives of wealthy private patients with such ‘bold’ and experimental surgery; nor is it likely that these patients would have consented to such operations. One other consequence of this shift in the balance of power in favour of the
doctor remains to be noted; that is, the way in which it made for more effective teaching. "While the paying patient had a legitimate right to object to being observed and prodded by a group of students, a person in receipt of charity was hardly in a position to complain about such invasions of his privacy." Abel-Smith's comment, which was made in relation to English hospitals, is equally applicable to French hospitals, as may be illustrated by reference to the Maison Royale de Santé. Campbell Stewart, writing in 1843, pointed out that virtually all of the Paris hospitals, with the exception of one or two special hospitals, such as those for the blind and for deaf and dumb children, were open to medical students, and in many cases clinical lectures were also delivered in the hospital. The Maison Royale de Santé, however, was not open to students, and no lectures were delivered there. Significantly, this appears to have been the only publicly owned hospital in Paris in which patients were required to pay, the fees varying from two to six francs a day. Stewart observed that as 'the object of patients in going to this hospital is to obtain private attendance and seclusion, it would be defeated were the public admitted to its wards; consequently it is strictly excluded'.

One last point, of some importance, remains to be made in relation to the problem of access to the patient's body. The body, it should be remembered, is in no way 'naturally' a peculiarly intimate and private thing; rather it has come to be so regarded gradually, and over a long time period, as part of what Norbert Elias has called the civilizing process. This process involved, among other things, and over a period of many centuries, the gradual elaboration and internalization (in the form of self-controls) of a whole series of taboos and precepts regulating such things as bodily functions and bodily exposure. Thus Parsons' comments on the problems of access, both to the patient's body and to information which might be considered private, should not be taken as being universally applicable, but are, it is suggested, applicable only to groups and to societies in which the civilizing process is comparatively advanced.

These controls on bodily functions and exposure, as Elias makes clear, had begun to become established among the upper classes in Western Europe long before the nineteenth century, and there is good reason to believe that by the nineteenth century these taboos had already filtered down to, and had become fairly well established among, the bourgeoisie. This was not yet, however, the case among urban workers and among the peasantry, for the configuration of social relationships within these groups was not such as to be conducive to the internalization of restraints. These people, living in cramped housing conditions, were still used to seeing their fellow men and women urinating, defecating and having sexual intercourse. The need for what we regard as 'proper' sanitary arrangements had not yet arisen; the body had not yet come to be seen—in the manner in which we have come to regard it—as something personal and intimate, not at least among the lower social classes.

This point is of considerable importance, for it was precisely people from these
classes, including probably many former peasants who had migrated from the rural areas, who made up the bulk of the hospital population in Paris. For such people, exposure of the body, even of the sexual organs, does not appear to have aroused the anxieties that would have been present in a patient of much higher social status. Consider, for example, the public character of the previously mentioned operation by Roux, an operation which involved exposing the sexual organs of a young woman to the gaze of no less than two hundred and fifty students. Or consider the following description of the Hôpital des Cliniques: 'Every student who visits Paris should attend here one or two months at least, if he desires to acquire a practical knowledge of midwifery. There are, on an average, two deliveries during each day in the year . . . . When a woman is taken in labour, notice is given to the initiated, by means of a lantern suspended from the porter's lodge, and the first two students who arrive are entitled to assist in the delivery; and in many cases to accomplish it themselves; those who arrive afterwards are accommodated with seats around a railing, serving as a partition between them and the patient, with those who are engaged about her. All, however, have an opportunity of seeing what is going on, and witnessing the birth of the child'. It is not possible to imagine a noble woman, or even the wife of a wealthy member of the bourgeoisie, submitting to what amounted almost to childbirth in public, but this does not, as far as one can judge, seem to have caused any great distress to most of the women who populated the Paris hospitals. Thus one writer, in drawing attention to the advantages of studying obstetrics in Paris, pointed out that 'From the circumstance of the French women of the lower orders being callous to exposure, and accustomed in sickness to public examinations, greater facilities are afforded in Paris for acquiring a knowledge of practical midwifery than are to be met with anywhere, except probably Dublin'. It is suggested that this 'callousness' to exposure was another factor which must have eased considerably the potentially critical problem of access to the patient's body, and which must also have made for more effective teaching.

Thus far, in an attempt to document the social structural conditions within the hospitals which were conducive to the development of modern medicine, we have examined the structure of the doctor-patient relationship, and some social characteristics of the patients themselves. So far in this analysis we have assumed that the patient is living; it should be remembered, however, that dead people were every bit as valuable, for both research and teaching purposes, as living ones. Thus the concept of a localized pathology was built up largely on the basis of correlating ante-mortem symptoms with local lesions revealed on the post-mortem table. Hence the final section of this paper concentrates on the problem of access, not to the bodies of living patients, but to the bodies of dead ones.

In this respect, as in many others, the French medical profession was particularly fortunate in having the support of the French government, a government noted for its encouragement and support for a wide range of scientific activities.
Conseil Générale d’Administration undertook to give a decent burial to all patients dying in the hospitals, on payment by relatives or friends of sixty francs. If, however, this sum had not been paid within twenty-four hours after notice of death had been sent to the next of kin, the corpse became the property of the Administration, and was immediately despatched to the dissecting rooms. The operation of this rule ensured there was always a healthy supply of subjects for dissection. Thus French practitioners, unlike their English colleagues, never had to resort to employing the services of the resurrection men in order to alleviate a chronic shortage of cadavers. Indeed, facilities for the study of anatomy were so good in Paris that English students of anatomy flocked to the French capital in their hundreds.

The support which the French medical profession enjoyed from the government in this respect is, perhaps, even more strikingly brought home by an incident which occurred in the early 1840s. Until this time, practitioners in hospitals had enjoyed the privilege of examining all cases that terminated fatally under their care. The importance of this was fully appreciated by the English practitioner Edwin Lee, who commented in 1835 that as 'the bodies of patients dying in the hospitals are examined, immense opportunities are afforded for the advancement of morbid anatomy; and the numerous valuable works which exist on the subject bear testimony to the zeal with which this important branch of medical knowledge is studied by French practitioners, who by this means are enabled to arrive at much greater accuracy of diagnosis in many diseases than the majority of the profession on this side of the channel'.

Not surprisingly, however, this privilege was frequently contested by the relatives of deceased patients, and in the early 1840s the Conseil Générale decided that when objections were made, it must be 'under peculiar circumstances alone that a physician should enforce his right'. This decision caused a great deal of dissatisfaction among members of the Medical Faculty in Paris, and Orfila, the Dean of the Faculty, resigned his seat in the Conseil Générale in protest. The Royal Academy of Medicine then petitioned the Minister of Public Instruction to withhold his approbation to the proposed change; this he did, and Orfila was immediately reinstated to his place in the council. Campbell Stewart commented 'Thus the surgeons and physicians in all the hospitals continue to examine, without hindrance, every case that is likely to present points of pathological interest'. Thus when the government did intervene directly to regulate the relationship between doctors and patients, it did so in order to maintain the already considerable rights of the former, at the expense of the latter. There was, it seems, no way in which the unfortunate hospital patient could avoid being poked and prodded, even in death.

In this paper, an attempt has been made to outline some of the salient characteristics of the social structure of early nineteenth century Paris hospitals, in order to spell out some of the ways in which this structure facilitated important changes in the structure of medical knowledge. It is not suggested, of course, that the many and
important innovations in medicine which were made in early nineteenth century Paris can be adequately understood simply in terms of the development of hospitals; a more complete analysis would require an examination of a number of other processes, including those listed in the opening paragraph of this paper. It is intended that some of these other processes will be dealt with in a subsequent paper.

Notes


3. ibid., p. 15.


7. Stewart, op. cit., p. 94.


13. Thus in England, practitioners such as Sir Samuel Garth, Mark Akenside and John Arbuthnot were as noted for their literary writings as for their medical publications, while others, such as Richard Brocketley and Richard Mead, were patrons of the arts, and were on intimate terms with the wits and poets of the period. For full biographical details of these physicians, see the *Dictionary of National Biography*. For other examples, including many from other parts of Western Europe, see A. Castiglioni: *A History of Medicine* (New York, 1947), pp. 654-655, and F. H. Garrison: *An Introduction to the History of Medicine* (Philadelphia and London, 1929), pp. 381-389. It is interesting to note that in England, this emphasis on the social graces, rather than on technical competence, persisted until well into the nineteenth century. In Anthony Trollope's *Doctor Thorne*, first published in 1858, Lady Arabella, wife of the Squire of Gresham'sbury prefers to have as her medical attendant the gentlemanly Dr. Fillgrave rather than the 'half-apothecary' Dr. Thorne, despite the fact that Dr. Thorne is the more competent practitioner.


One important difference between French and English hospitals should perhaps be noted here. In English hospitals, the status of physicians and surgeons was normally a purely honorary one, whereas French hospital doctors received a salary. The salaries were, however, not large—according to Stewart they varied between 600-1800 francs a year—and many hospital doctors also held appointments in the university, in addition to practising privately.

17. Ackermehct, op. cit., p. 15.


22. Rosen, op. cit., p. 147.

23. Stewart, op. cit., p. 34.

24. ibid., pp. 47, 37.

25. ibid., p. 98.


27. ibid., p. 134.


29. ibid., p. 892.


31. ibid., p. 205.


33. ibid., p. 226.

34. ibid., p. 102.

35. ibid., p. 233.

36. Perhaps a more extreme example, from a different society, which illustrates even more clearly the way in which the vulnerability of the patient is socially structured, is provided by the development of gynaecology in America in the middle years of the last century, and particularly by the work of J. Marion Sims who, in 1849, performed the first successful operation for vesico-vaginal fistula. Significantly, all of Sims' experimental operations were performed upon negro women. It is interesting to note that Sims agreed with the owners of the slaves that if they would give him the slaves 'for experiment', he would keep them at his own expense. Some of these slaves Sims kept for as long as four years, during which time he performed numerous operations on them; one woman had as many as thirty operations in all. See J. Marion Sims: The Story of My Life (New York, 1884, reprinted 1968), pp. 226-246.

37. In this respect, the situation of patients in some public hospitals in Paris does not appear to have improved much until comparatively recent times. George Orwell, in writing of his experiences as a patient in a Paris hospital in 1929, pointed out that he saw 'two students kill a sixteen-year-old boy, or nearly kill him (he appeared to be dying when I left the hospital, but he may have recovered later) by a mischievous experiment which they probably could not have tried on a paying patient'. The relatively powerless position of the public hospital patient, even at this time, is brought out by Orwell's comment that 'If you are seriously ill, and if you are too poor to be treated in your own home, then you must go into hospital, and once there you must put up with harshness and discomfort, just as you would in the army'. See Orwell's essay 'How the Poor Die' in Collected Essays, Journalism and Letters (4 vols., Penguin, 1970), Vol. 4, pp. 261-272.

38. Abel-Smith, op. cit., p. 18.

40. I am grateful to Norbert Elias and Eric Dunning, of the Department of Sociology, University of Leicester, for allowing me to read Dunning’s draft of the translation which they are jointly preparing of Volume I of Elias’ Über den Prozess der Zivilisation (2 vols., Berne, 1939, 2nd edition, Berne and Munich, 1969).

41. This does not imply a criticism of Parsons, for the chapter in which he develops these ideas is quite specifically titled ‘Social Structure and Dynamic Process: The Case of Modern Medical Practice’ (my italics).

42. In ‘filtering down’ to the bourgeoisie, these taboos were, of course, modified in certain ways. One of the more important of these changes related to the type of relationship, and the type of situation, in which these taboos and precepts became operative. Thus among the court aristocracy, they were operative only in the context of a specific type of relationship, that is, among persons of equal rank. When, however, they became an important component in the structure of affect-control among bourgeois groups, they began to be universalized, that is, they were held to apply to all forms of relationships, and to all situations.

43. Stewart, op. cit., p. 42.

44. Ibid., p. 124.


46. Stewart, op. cit., p. 98.

47. The 1828 Select Committee on Anatomy estimated that at that time there were about two hundred English students of anatomy in Paris. See the Report from the Select Committee on Anatomy, 1828, (568), p. 7.


49. Stewart, op. cit., p. 125, footnote.

The Development of Medical Ethics:

A Sociological Analysis

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THE DEVELOPMENT OF MEDICAL ETHICS
- A SOCIOLOGICAL ANALYSIS

by

IVAN WADDINGTON

It is a curious fact that despite the rapidly growing volume of literature on the professions, little work has been done by sociologists on the development of professional ethics. This omission becomes doubly curious when one considers the central importance attributed to professional ethics in much of the literature on professions; given this situation one can hardly aspire to an adequate sociological analysis of the development of professional occupations which does not include an analysis of the development of professional ethics. This paper aims, in a modest way, to help fill this gap by analysing the origins and early development of modern medical ethics.

The most famous of all codes of medical ethics is probably the Hippocratic Oath, which Edelstein dates from the fourth century B.C.1 From time to time, slightly modified forms of the oath were developed, for example to allow Christians to take what was originally a pagan oath, and although there was no body which enforced the ethical rules contained in the Hippocratic Oath, it appears to have had some influence on medical practice. Thus Chauncey D. Leake has pointed out that prior to the end of the eighteenth century, "the medical profession tried generally to handle its ethical problems on the basis of the Greek tradition of good taste and personal honor".2 However, if we wish to understand the development of specifically modern codes of medical ethics, we must look not to ancient Greece, but to nineteenth-century England, and in particular, to the work of Thomas Percival, whose Medical ethics, published in 1803, marks an important break-point between ancient and modern medical ethics. As Leake has pointed out, it was Percival who, more than any other person, effected the "transition from the broad principles of Greek medical ethics to the current complicated system".3

This view of Percival as the founder of modern codes of medical ethics is shared by most medical men. Thus Forbes has referred to Percival's work as a "prominent landmark in the progress and evolution of medical ethics", and adds that "No later work has modified in any material degree the precepts and practice defined by Percival for the conduct of a physician".4 Barton has written that Percival "compiled the first modern code of medical ethics",5 while McConaghey comments that the "rules of conduct of modern times stem from the small book published in 1803 by Thomas Percival".6

While it is difficult to over-estimate the importance of Percival's book, it would be quite wrong to see it, in an almost asocial sense, purely as the work of a gifted individual, for Percival's work is simply the most famous of a number of publications by
English practitioners in the first half of the nineteenth century, all of which indicate a major concern with ethical problems in the practice of medicine. These included W. O. Porter's *Medical science and ethics*, published in 1837, and Abraham Banks' *Medical etiquette*, published in 1839. This concern with ethical problems also found expression in articles and editorials on medical ethics in all the major medical periodicals, as well as in the considerable number of letters from readers dealing with similar problems. Finally, mention must be made of associations, like the Manchester Medico-Ethical Association, which were founded specifically to deal with ethical problems, and of the development of medico-ethical committees in medical associations founded for more general purposes, such as the British Medical Association, which set up its own medico-ethical committee in 1853.

Thus Percival was not working alone, for his concern with medico-ethical problems was shared by many of his contemporaries. Our problem, then, is to explain why practitioners in England were concerned with medical ethics at this time. In general terms, the attempt to formulate codes of professional ethics, and to establish institutions to enforce those codes, can be seen as an attempt, by professional men themselves, to cope with certain recurrent problems with which they are faced in the practice of their profession. These problems are not individual problems, but problems which are shared by many members of the occupational group in question. Thus, to ask why English practitioners were concerned with medical ethics at this time, is to ask what sort of problems they habitually faced in the practice of medicine. It is the task of this paper to answer this question.

Before, however, we come to this question, we must briefly analyse a precondition, though by no means a sufficient condition, for the development of professional ethics, namely the breakdown of the patronage system. The attempt to formulate and enforce a code of professional ethics represents a development towards what has been termed “colleague control”—that is, a form of social control in which the professional activities of practitioners are regulated by the actions and sentiments of their professional colleagues. Yet colleague control is only one of a variety of forms of occupational control, and prior to the nineteenth century it was by no means the dominant form of control of professional activities. Thus the eighteenth century was an age of patronage, and patronage typically gives rise to a structure not of colleague control, but of client control. Under patronage the aristocratic and wealthy client is the dominant partner in the client-practitioner relationship; the client, by virtue of the wider social bases of his power, is able to define both his own needs, and the manner in which those needs are to be met. Moreover, the ties which bind the practitioner to his patron or patrons are those of loyalty and personal subservience, and as Carr-Saunders and Wilson have pointed out, “Men who are in that condition of personal subservience do not easily associate with their fellows. Association might seem to indicate a striving towards an independence that would be incompatible with the relation of client to patron.” A similar argument has been more recently expressed by Johnson, who points out that patronage is associated with a fragmented, locally oriented occupational group. Under patronage, the practitioner defers to and identifies with his patron or patrons, rather than with his professional colleagues. Under these conditions, the solidarity of the occupational group is relatively under-developed,
while the "authority of the patron reduces the clear function of ethics and autonomous
disciplinary procedures". A

It is clear, then, that a well-developed patronage system is inimical to the develop­
ment of any form of colleague control, including professional ethics. The breakdown
of the patronage system, concomitant with the widening of the market for medical
services in the nineteenth century, can thus be regarded as a precondition for the
development of codes of medical ethics. It is, however, proper to regard this as a
precondition, rather than as a direct cause of the development of medical ethics, for
it does not, of itself, answer the question of why medical practitioners were con­
cerned with medico-ethical problems at this time. For an answer to this question, we
must look elsewhere.

Traditionally, sociologists have argued that the development of professional ethics
must be seen within the context of practitioner-client relationships. In 1933, Carr-
Saunders and Wilson suggested that "Just as the public may fail to distinguish between
competent and incompetent, so it may fail to distinguish between honourable and
dishonourable practitioners. Therefore the competent and honourable practitioners
are moved mutually to guarantee not only their competence but also their honour.
Hence the formulation of ethical codes." A few years later, T. H. Marshall argued
that "Ethical codes are based on the belief that between professional and client
there is a relationship of trust, and between buyer and seller there is not." Since
the time that Carr-Saunders and Wilson and Marshall wrote, the suggestion that
practitioner-client relationships are crucial to an understanding of professional
ethics has become almost a sociological orthodoxy. Characteristically, those who
pursue this line of argument suggest that for a variety of reasons, but primarily because
of his ignorance, the client is unable to judge the quality of the professional services
which he receives. Consequently, the client is very vulnerable to exploitation by the
unscrupulous practitioner. The development of professional ethics is seen as a response
to this problem of social control. Thus the professional group itself undertakes to
guarantee the integrity of its members by the development and enforcement of codes
of professional ethics. In this way, the risk of exploitation of the client is minimized.
Specifically in relation to medical ethics, this type of explanation seems to be shared
by most medical historians and, not surprisingly, by medical practitioners themselves.

This approach, however, has been developed in the absence of any detailed empirical
investigation of the development of codes of professional ethics. How well, then,
does this approach enable us to understand the development of modern medical
ethics? If we examine Percival's Medical ethics carefully, we find little evidence that
Percival was concerned primarily with ethical problems in the doctor-patient relation­
ship. If we exclude Percival's last chapter, which is on medical jurisprudence rather
than medical ethics, we find that out of a total of forty-eight pages, only half-a-dozen
or so are devoted to a consideration of ethical problems in the doctor-patient relation­
ship. Moreover, his advice to practitioners on how to behave towards patients is,
for the most part, of a highly general kind, very much in keeping with the Greek
tradition; there is thus nothing specifically modern about it. Thus Percival advises
practitioners to "unite tenderness with steadiness", and "condescension with
authority". All cases should be treated "with attention, steadiness and humanity".
Percival gives little advice on how to cope with specific problems in the doctor-patient relationship, although he does suggest that there should be no discussion of a case before the patient, that practitioners should observe "secrecy and delicacy" with female patients, and that the "familiar and confidential intercourse, to which the faculty are admitted in their professional visits, should be used with discretion and with the most scrupulous regard to fidelity and honour".

If, however, comparatively little space is given to a consideration of ethical problems in doctor-patient relationships, a great deal of space is devoted to the establishment of a set of rules for regulating the relationship between practitioners. Moreover, the advice which Percival gives to practitioners in this context is much more concrete, and more detailed. Consider, for example, his advice concerning the conduct of consultations. "In consultations on medical cases", he says, "the junior physician present should deliver his opinion first, and the others in the progressive order of their seniority. The same order should be observed in chirurgical cases." Even more detailed is his advice on consultations between physicians and surgeons. Thus, "In consultations on mixed cases, the junior surgeon should deliver his opinion first, and his brethren afterwards in succession, according to progressive seniority. The junior physician present should deliver his opinion after the senior surgeon and the other physicians in the order above prescribed." Moreover, to resolve any uncertainty arising in situations where the lines of seniority are not clearly defined, Percival even sets out a method for assessing the relative seniority of practitioners engaged in consultation with each other.

The fact that Percival's book is concerned primarily with regulating relationships between practitioners has been clearly pointed out by Leake, who makes a distinction between medical etiquette and medical ethics. Medical etiquette, he suggests, "is concerned with the conduct of physicians toward each other, and embodies the tenets of professional courtesy. Medical ethics should be concerned with the ultimate consequences of the conduct of physicians toward their individual patients and toward society as a whole." He notes that "The term 'medical ethics', introduced by Percival, is really a misnomer ... it refers chiefly to the rules of etiquette developed in the profession to regulate the professional contacts of its members with each other." Nor is this surprising, for Percival's work was, in fact, written specifically in order to resolve a purely intra-professional dispute. In 1789, an epidemic of typhoid or typhus taxed the capacity of the Manchester Infirmary, and the trustees decided to double the staff. The surgeons and physicians already on the staff took this as a reflection upon their efforts, and resigned. In the confusion attending the change of staff, there was apparently a good deal of friction between the practitioners attached to the hospital, and Percival, who was physician extraordinary to the infirmary, was asked to draw up a "scheme of professional conduct relative to hospitals and other medical charities". The result was a small book which was printed for private distribution in 1794, and which appeared in a revised form in 1803 as Percival's Medical ethics. Leake has pointed out that "The circumstances under which Percival's 'Code' was written, made it necessary for him to place considerable emphasis on medical etiquette", while Lester King has observed that the book was designed "specifically to establish greater harmony among the physicians who had the care
of the indigent sick, and was in no sense an attempt to explore any vague ethical
generalities". 88

Despite the special circumstances under which Percival wrote, his book was by
no means unique, in terms of the kinds of problems with which it dealt, for Percival's
concern to regulate relationships between practitioners was shared by many of his
contemporaries. Thus Abraham Banks' *Medical etiquette* 89 was, as the title suggests,
concerned almost entirely with intra-professional relationships. The only point at
which the doctor-patient relationship becomes problematic for Banks is when one
practitioner is called in to attend the patient of another practitioner, a situation
which only becomes problematic because another practitioner is involved in the
management of the case. A similar story is told by the letters to the *Lancet*, in which
allegations of unprofessional behaviour focus almost entirely around the conduct
of consultations and the poaching by one practitioner of the patients of another. 90

Another major intra-professional problem, which was also dealt with by Banks 91
concerned the division of fees in cases where the regular practitioner was unable to
attend and another practitioner was called in. In 1845, the *Lancet* reported that a
meeting had been called in London to establish some rules governing fee-splitting
in such cases. The *Lancet* commented that "Some general arrangements of this
nature had long been needed" and it went on to express the hope that such an arrange­
m ent would help remove "the stigma cast upon the profession, that it displayed no
more cohesion than a 'rope of sand'." 92

In fact, virtually all of the literature from this period supports the idea that rela­
tionships between practitioners were much more sensitive, and much more in need
of regulation, than were relationships between practitioners and their patients.
Occasionally, the tensions between practitioners gave rise to open hostilities. Thus in
1837, the *Lancet* carried an editorial on a dispute between certain medical practi­
tioners in Newport and Monmouth. In the course of the dispute, which was publicized
in the *Monmouthshire Merlin* for 25 November, the practitioners involved took to
"placarding" one another, that is distributing bills critical of their opponents. 93 In 1845,
the *Lancet* devoted another editorial to a conflict between two practitioners in Frome,
Somerset. This dispute, like many others at the time, arose as a result of a consultation
between the two practitioners, both of whom had published pamphlets criticizing the
other. The *Lancet* observed that one of the practitioners "heaps insult upon insult on
his opponent, on his opponent's brother—whose part in the case was merely that of a
spectator—and even attacks the entire medical profession of Frome". 94

These well-publicized conflicts merely represented the tip of the iceberg however,
for conflicts between practitioners were endemic at this time, and it seems to have
been appreciated by practitioners themselves that the major problems with which
they had to contend arose from the internal divisions and tensions within the pro­
fession. Thus Abraham Banks referred to the "prevalence of illiberality in country
towns and villages; the jealousy existing between individual practitioners, who
frequently, under the mask of candour and professed friendship, undermine each
other's reputation, and never lose a chance of sinking one another in public estima­
tion, when this can be done with seeming good grace and kindness". 95 That relation­
ships between provincial practitioners were often strained will come as no surprise
to those who are familiar with Trollope's *Doctor Thorne*, it is, however, difficult to see how they could be more strained than those between London practitioners when the *Lancet* could refer to hospital consultants, and to those who controlled the Royal Colleges as "crafty, intriguing, corrupt, avaricious, cowardly, plundering, rapacious, soul-betraying, dirty-minded BATS". Clearly, however, Banks had this kind of intra-professional conflict very much in his mind; his object, he said, was "to promote concord and harmony amongst the several branches of the profession". A similar point was made two years earlier by W. O. Porter, in his *Medical science and ethics*, when he called upon doctors to follow the golden rule, "Do unto all men as you would that they should do unto you". He hoped that we "should not then be exposed to feel, or witness, or even hear of those feuds, which sometimes arise between members of the profession, so injurious to the interests of all concerned, and so derogatory to that high character, which it is our duty to preserve, and should be our chief aim to raise in the estimation of the public".

This same point was repeated over and over again by those writing on medical ethics. Thus in 1845, a correspondent of the *Lancet* called for the introduction of "a standard or rule to guide doctors in their professional activities". However, he went on in a somewhat despondent manner, "Or, is this subject too delicate, and must we continue to live on, hoping for better feelings and deportment in those who have hardly a fair word to use for their brother? Perhaps it is doubtful, after all, whether any set of rules would unite a body so disaffected as ours". Perhaps most telling, however, are the comments of the author of a paper on medical ethics which was published in the *London Medical Gazette*. The writer, W. B. Kesteven, pointed to the "urgent need of a generally acknowledged principle whereon to base the rules of medical ethics", and claimed that "it is doubtless the want of some such principle that permits the jealousies, bickerings, and calumnies which distress and divide the different branches and interests of the profession". He then went on to ask "Is it not an unenviable paradoxical notoriety, that a profession pre-eminently benevolent and ... eleemosynary to all beyond its own immediate sphere, should towards its own members be proverbially uncharitable and litigious? Alas! will the time never be that men shall apply to its members the eulogium so unwittingly extorted from the pagans of old, 'See how these Christians love one another'? Or rather, how long shall it be that the world shall continue to say, 'See how these doctors hate one another'?"

This argument is particularly telling, because it indicates quite unambiguously that relationships between doctors and the wider society, including patients, were characterized by benevolence and charity on the part of practitioners. The same point was made in an editorial in the *Lancet* in 1842, and indeed, it seems to have been a point on which the medical profession prided itself. The everyday problems facing medical practitioners, it is clear, arose not in their relationships with their patients, but in their relationships with their professional colleagues, relationships which all too frequently were characterized by tensions, by hostilities, by accusations and counter-accusations. The development of medical ethics, it is suggested, can best be understood as an attempt to regulate these tension-ridden relationships so as to reduce the amount of potentially very damaging intra-professional conflict.
In order to understand the reasons for this endemic conflict within the medical profession, we must have some understanding of the rapidly changing structure of medical practice at this time. Traditionally the law had recognized only three types of medical practitioners: physicians, surgeons, and apothecaries. These three groups were organized in a hierarchical structure, with physicians forming the “first class of medical practitioner in rank and legal pre-eminence”. By the Statute of 32 Henry 8, physicians were allowed to practise physic in all its branches, among which surgery was included. However, the disdain which physicians, as a body of learned men, felt for manual work, had led to a contraction in their duties, and by the eighteenth century, the practice of the physician was held to be properly confined to prescribing of drugs to be compounded by the apothecary, and in superintending operations performed by surgeons in order to prescribe what was necessary to the general health of the patient, or to counteract any internal disease. The controlling body for physicians was the Royal College of Physicians of London, a small and exclusive body, very conscious of the necessity to maintain the high status which physicians had long enjoyed.

In sharp contrast to physicians, surgeons had long been regarded as craftsmen rather than gentlemen. The surgeons had been united with the barbers in the Company of Barber-Surgeons until 1745, in which year they formed a separate organization, the Company of Surgeons, which subsequently became the Royal College of Surgeons of London in 1800. The proper sphere of practice of the surgeon was held to consist generally in the cure of all outward diseases, and in the use of surgical instruments in all cases where this was necessary.

The lowest order of the medical profession, the apothecaries, had been organized in the Society of Apothecaries since 1617. The charter of the Society required seven years’ apprenticeship to a member as an essential qualification for admission to the freedom of the Company, and stated that at the end of seven years “every such apprentice . . . shall be examined, proved, and tried concerning the preparing, dispensing, handling, commixing and compounding of medicines”. However, by the early part of the eighteenth century, the apothecaries had successfully grafted medical on to pharmaceutical practice, and had won legal recognition of their right to “administer medicine of their own authority, and without the advice of a physician.”

This tripartite structure was enshrined not only in the internal institutional structure of the profession—in the sense that there were separate licensing bodies for physicians, for surgeons and for apothecaries—but also in the legal system. Thus the “orders” of the profession were hierarchically ranked, and each grade of practitioner had privileges which were legally defined. The general concept of the qualified or registered practitioner had no place in English law prior to the Medical Act of 1858; instead there were separate laws relating to physicians, to surgeons, and to apothecaries.

If, however, this tripartite structure was more or less clear in formal terms, it had become, by the beginning of the nineteenth century, anything but clear in practice. The social and economic changes associated with the agricultural and industrial revolutions—too complex to be gone into here—had not only expanded the demand for medical care, but had also created demands for a new type of medical care. Under the impact of these new demands the divisions between physicians, surgeons, and
Apothecaries were steadily breaking down. Thus, from 1750 onwards, a rapidly growing number of practitioners were combining the practice of medicine, surgery, midwifery and pharmacy to form a quite new professional role, that of the general practitioner. By the 1830s, general practitioners were by far the most numerous class of medical men, probably providing some ninety per cent of the qualified medical care in England. Numerous witnesses who gave evidence before the Select Committees of both 1834 and 1847–48 testified to the fact that there were hardly any practitioners, even in London, who could confine their practice to pure medicine or surgery.

Not all medical men were engaged primarily in general practice, however, for the growth of hospitals in the eighteenth and nineteenth centuries had given rise to a much smaller, but very important, class of consulting physicians and surgeons who owed their positions as consultants primarily to their hospital appointments. Thus in the period 1750–1850 the traditional tripartite structure was being steadily eroded and replaced by the emergence of the modern structure of medical practice, based on the differentiation between general practitioners and the hospital-based consultants.

While the traditional tripartite structure was clearly breaking down, however, an institutional structure appropriate to this new professional differentiation was slow in developing. This resulted in a very confused situation, in which definitions of roles and statuses within the medical profession were very unclear. As a correspondent of the Lancet pointed out in 1841, “Everything connected with our profession is, at present, in a state of disorder and uncertainty; its laws are in abeyance; and young men, about to commence their medical studies, are quite at a loss what to expect, or what plan of education to pursue”. The medical profession in the first half of the nineteenth century was, as Leake has bluntly but accurately characterized it, “a mess”, and within this ambiguous and fluid situation, different types of practitioners “jockeyed for positions of prestige and power”.

This jockeying for position was related to the prevailing confusion surrounding the division of labour within the profession, a problem which was intimately related to the different statuses attributed to different kinds of medical work. Thus the role of the general practitioner cut across the traditional tripartite division of labour, since it necessarily combined the practice of medicine, surgery, pharmacy, and midwifery. A number of practitioners however—particularly the consulting physicians and surgeons—were bitterly opposed to the incorporation of what they regarded as purely manual or trading activities into the doctor’s role, for they feared that such a development threatened the high status which physicians had long enjoyed, and which surgeons had recently attained. Thus the Royal Colleges of Physicians and Surgeons, which were dominated by the consultants, adopted a variety of policies designed to maintain the purity of medicine and surgery undiluted by manual and trading operations, and to stem the rise of the general practitioner. Among other things, they refused to broaden the scope of their examinations to cover anything other than pure medicine and surgery respectively, and to allow general practitioners on to their governing councils. The general practitioners in turn resented what they saw as an attempt to deny them their proper place within the profession and to condemn their characteristic mode of earning a livelihood as a low-status
medical occupation, unfit for gentlemen. From the second half of the eighteenth
century the general practitioners launched a campaign for the democratic reform of
the medical corporations, for the reform of medical education and licensing, for the
abolition of the divisions between physicians, surgeons, and apothecaries, and for
the recognition of general practice as a legitimate and honourable professional
activity. This campaign, which lasted for a hundred years, was bitterly fought, and
gave rise to extremes of vituperation and personal insult, in which the *Lancet*
in particular excelled, and occasionally it gave rise to the use of physical violence by one
section of the profession against another. The widely held picture of a profession
as a harmonious community is not one which can readily be applied to the medical
profession in the nineteenth century.

This analysis provides a major key to the understanding of why ill feeling and
disharmony so often characterized relationships between practitioners. It also helps
us to understand why the problem of defining what kinds of activities should be
undertaken by what kinds of practitioners figured prominently in the literature on
medical ethics. Thus only in these terms, it is suggested, can we understand Percival's
lengthy discussion of the relationships which ought to prevail between the different
"grades" of practitioners. Of Percival's three chapters on medical ethics, the whole of
the third chapter is devoted to a discussion "Of the Conduct of Physicians towards
Apothecaries", while other statements on the relationships between physicians,
surgeons and apothecaries are scattered liberally throughout his work. Thus in his
advice on the conduct of mixed consultations, cited earlier, Percival showed a clear
understanding of the nice status distinctions between physicians and surgeons in his
recommendation that the most junior physician present should deliver his opinion
after the most senior surgeon had delivered his.

On issues of this kind, Percival was a conservative—according to Sir George
Clark, "the best conservative opinion" of his time—and accordingly he advised his
fellow practitioners to maintain the traditional division of labour within the pro-
fession. Thus in his chapter on hospitals, he advised that "A proper discrimination
being established, in all hospitals between the medical and chirurgical cases, it should
be faithfully adhered to by the physicians and surgeons on the admission of patients". Similarly, in the chapter on private practice, he recommended that "In large and
opulent towns the distinction between the provinces of physic and surgery should
be steadily maintained. This distinction is sanctioned both by reason and experience. . . . Experience has fully evinced the benefits of the discrimination recom-
ended, which is established in every well regulated hospital, and is thus expressly
authorized by the faculty themselves and by those who have the best opportunities
of judging of the proper application of the healing art. No physician or surgeon,
therefore, should adopt more than one denomination, or assume any rank or privileges
different from those of his order." Similarly, in his chapter on the relationships
between physicians and apothecaries, he suggests that physicians should refuse a
request to visit the patients of an apothecary, in the latter's absence. "Physicians",
he argued, "are the only proper substitutes for physicians; surgeons for surgeons;
and apothecaries for apothecaries." Thus Percival tried to present guidelines which
would prevent the continual disputes over the division of labour within the profession;
his solution, as we have seen, was to call for the maintenance of the traditional
divisions within the profession.

While most practitioners seem to have agreed that the breakdown of the traditional
tripartite division of labour was a major cause of the jealousies and tensions within
the profession, few were willing to go along with Percival's conservative remedy.
The radicals' position was clearly set out in a long paper on medical ethics by Thomas
Laycock, which was published anonymously in the *British and Foreign Medico-
Chirurgical Review* in 1848. Laycock pointed out that the profession "seems little
better than a chaos; the whole mass is upheaving; decomposition and recomposition
are going on; but we can discern no great principles by which coherence and strength
may be given to the discordant elements. It is quite impossible that the intelligent
lay public will notice the professional desire for organization and legislation, so long
as the impelling motives are nothing more dignified than sectional interests, grade-
prejudices, or interested clamours in a pecuniary sense". "How", he asked, "can
members of Parliament and the educated classes esteem a profession, the members of
which mutually disparage each other?" Laycock then went on to examine the
squabbles over the division of labour within the profession. "All bodies of men" he
argued, "are intolerant of any departure from principles and practices that have
become conventional. Although such departure may have nothing whatever in it
morally wrong, yet it is visited 'with the utmost rigour of the law'—that may have
been conventionally established. Thus physicians fully engaged in practice will
bitterly regard the young physician who, feeling the pressure of the *res augusta domi*,
may exercise any surgical talent he may possess, or who, suspecting that his
medicamina are not well compounded, or of a spurious quality, may look to the
manufacture of his powder, or point his own guns." He pointed out that even though
all types of practitioners co-operated harmoniously in organizations like the Royal
Medico-Chirurgical Society, the educational institutions continued to "raise their
Shibboleth before the public, before Parliament, and in the profession, and establish
their differences where there is hardly any distinction". The leading men in the
College of Surgeons treated medical cases as frequently as surgical ones. "To all
purposes, and in every way, the surgeon is a physician, with the ability to operate
chirurgically superadded to his medical acquirements, and is conventionally permitted
to operate, prescribe, and receive his fee, so long as he calls himself 'surgeon'. But
led him add M.D. to his name, and conventionalism forthwith binds up his right
hand, severs him from his College, and circumscribes the sphere of his usefulness."
Laycock added that "if it could be proved that this line of demarcation, already
obliterated in the voluntary associations, is of any use whatever to either the pro-
fession or the public when drawn between two classes of practitioners, in which the
difference of education and attainments is now at least really but nominal, we would
acquiesce at once in the arrangement. But it has yet to be shown that a union of
these two educational institutions, and a reorganisation on a broad base of ethical
principles, would either render the surgeon less skillful, or the physician less educated
or intellectual. The whole matter is indeed hardly capable of serious argument."
Thus Laycock called for the abolition of those professional divisions which Percival
had defended in 1803. Only by taking such a step, argued Laycock, could the intra-
professional squabbling and bickering be ended. Thus he concluded his paper by calling on enlightened provincial practitioners to place the organization of the profession on "its proper basis", or else the profession would remain "as it is—a chaos of conflicting elements".

Shortly afterwards, the *Lancet* gave Laycock's paper its "warmest approbation". Quoting extensively from the article, the *Lancet* said "there are no passages in the article... with which we more cordially agree than those which describe the unworthy jealousies which rise between some among the different classes of the profession, when any man dares to step out of his proper line; when the physician or surgeon, for instance, trenches upon the province of the general practitioner; when the general practitioner aspires to the work of the surgeon or physician; or when the physician and surgeon dare to defy artificial distinctions, and pass from one department to the other." The *Lancet* added "how constantly have we dwelt on the meretricious separation, the unworthy caste-division, which seeks to make the highest surgeon lower than the physician, and the highest general practitioner lower than both". The *Lancet*, of course, had, since its foundation in 1823, campaigned consistently for the abolition of the tripartite structure, and by the middle of the century there was widespread agreement amongst doctors that there could be no end to the disharmony and tensions within the profession as long as the tripartite structure remained. It is hardly surprising that this issue should have figured prominently in the literature on medical ethics.

As the tripartite structure was steadily being eroded, so the modern structure of medical practice, based on the differentiation between consultants and general practitioners, was beginning to emerge; indeed, these were, in reality, different aspects of the same process. But just as the breakdown of the tripartite structure gave rise to problems, so too did the emergence of the consultant-general practitioner relationship. As the hospitals developed, so they gave rise to a class of consulting physicians and surgeons, and the practice of calling in a consultant to help in the management of particularly difficult or ambiguous cases became increasingly common. Relationships between general practitioners and consultants were frequently characterized by hostilities and tensions however, for both roles were, in a real sense, new roles, and as such, they had not yet, at this period, become as clearly differentiated and institutionalized as they are today. In particular, there was one critical area of overlap between the role of the consultant and the role of the general practitioner, an area of overlap which not only differentiates the nineteenth-century consultant from the present-day consultant, but which was also at the root of much of the conflict which characterized consultations in the nineteenth century.

This critical area of overlap arose because consultants did not then—as they do now—confine their practice to consulting work, but also normally acted as general practitioners to small numbers of wealthy clients. In addition there were a large number of practitioners—particularly in the provinces, where consulting work was normally less readily available—who derived the major part of their income from general practice, but who also occasionally acted as consultants within their own locality. The result was that consultations were normally held between two practitioners, both of whom, to some extent, were in general practice; thus there was a real
element of competition involved, particularly for wealthier clients. Within this situation, mutual suspicion and hostility between consultants and general practitioners were common. Allegations by general practitioners that consultants were trying to poach their patients, either by calling on the patient a second time without the knowledge of the regular attendant, or by implicitly or explicitly criticizing the therapy recommended by the latter, were common. From the 1830s onwards, the *Lancet* published numerous letters from practitioners alleging breaches of professional etiquette, the most common complaints being those which related to the conduct of consultations and the poaching of patients. In 1849, W. B. Kesteven referred to the "censurable condemnation of a professional brother, whether of a higher or lower grade, by looks, gestures, innuendos, etc. For example, a physician called in consultation takes occasion in the absence of the general practitioner to hint that a different treatment should have been adopted; or by indirect means, such as *friendly* visits, etc., supplants the ordinary attendant, or destroys his patient's confidence".®

In 1854, the *Association Medical Journal*, in reply to a correspondent who complained of the conduct of a consultant, agreed that it was easy for a consultant to:

Convey a censure in a frown,  
And wink a reputation down.

The *Association Medical Journal* went on to point out that "extreme watchfulness and honesty of act and feeling are essential requisites in this class of practitioners".®

The conflict between general practitioners and consultants—which was in effect a demarcation dispute—smouldered on throughout the nineteenth century, and towards the end of the century, in 1886, the lines of conflict were more clearly articulated than ever before with the foundation of the Association of General Practitioners. The Association, which was founded with the aim of forcing consultants to confine their activities to consulting practice, would have nothing to do with "so-called consultants who practised as general practitioners... It will not seek to discredit them, nor will its members refuse to meet them when required to do so; but it will exert all its individual and collective influence in favour of those who act as consultants as the term is understood by this Association".®

Given this situation, it is hardly surprising that a number of writers, from Percival onwards, should see consultations and the poaching of patients as major areas requiring regulation by a code of medical ethics. Percival’s advice on these points is quite detailed. Thus we have seen that Percival not only lays down the order in which parties to a consultation should deliver their opinion, but also suggests a way of calculating the seniority of the respective practitioners involved. Punctuality should be observed in consultations, and "No visits should be made but in concert, or by mutual agreement".® When consultations are held, "no rivalship or jealousy should be indulged. Candour, probity and all due respect should be exercised towards the physician or surgeon first engaged."® "Officious interference, in a case under the charge of another, should be carefully avoided."® If a practitioner is called to a patient under the care of another practitioner, he should always observe "the utmost delicacy towards the interest and character of the professional gentleman, previously connected with the family".® The practitioner should "interfere no farther than is
absolutely necessary with the general plan of the treatment; to assume no further
direction, unless it be expressly desired; and, in this case, to request an immediate
consultation with the practitioner antecedently employed." Abraham Banks deals
with many similar problems, advising consultants not to call on patients without the
general practitioner being present, giving advice on how to divide the fee when two
practitioners consult, on how to act when a second party is called in to decide upon
the treatment of another practitioner, and on what to do (and what not to do)
when one practitioner is sent for to the patient of another practitioner. W. Fraser's "Queries in medical ethics", a series of questions and answers on ethical
problems published in the London Medical Gazette in 1849, no less than fourteen of
the twenty-seven queries deal with consultations, and with taking over the manage­
ment of a case from another practitioner.

Medical practitioners, it is clear, were no more given than any other section of
the educated classes to the consideration of abstract philosophical principles. Rather,
their concern with medical ethics was a practical concern, arising from certain re­
current problems with which they were faced in the day-to-day practice of their
profession. In this paper it has been suggested that these practical problems arose
primarily within the context of relationships between practitioners, as a result of
certain structural tensions within the profession. The commonly held view that
professional ethics develop primarily in order to regulate relationships between
practitioners and their clients finds little support from an analysis of nineteenth-
century writings on medical ethics, in which ethical problems in the doctor-patient
relationship occupy only a minor place.

It is not suggested, of course, that an understanding of practitioner-patient re­
lationships is irrelevant to an understanding of medical ethics, for there are clearly
passages in Percival's work, as in the work of other writers, which relate to the
doctor-patient relationship. What is suggested is that the importance of the doctor-
patient relationship for an understanding of medical ethics has been very considerably
overstated, and that the development of medical ethics may be much more closely
related to the need to regulate relationships between practitioners than has com­
monly been held.

Nor is it claimed that this analysis is equally applicable to the development of
codes of professional ethics in all professional occupations at all times, for the signi­
cficance of colleague relationships, as well as the potentiality for intra-professional
conflict, are likely to vary according to different structural conditions. Nevertheless,
the analysis might well be applicable to other occupations which emerged as modern
professions in the nineteenth century, for the changing pattern of demand for pro­
fessional services during that period produced some similar changes, resulting in
similar tensions, within other professional groups. However, the structural con­
ditions under which many new occupations—including many para-medical occupa­
tions—are today striving for professional status, are quite different, and it would be
foolish to expect them to follow the characteristic nineteenth-century pattern of
professional development.

However, the case of medicine is an important test case, if only because the medical
profession has so frequently been used as the prototypical profession, on the basis of
which a number of models of the professions have been constructed by sociologists. The conventional explanation of the development of professional ethics is not valid, it is suggested, even for the prototypical profession, and it is perhaps time that sociologists took a harder, more critical look at the conditions under which professional ethics develop, and at the functions which they perform. It would seem that for too long sociologists have accepted on trust the bland assurances of the professionals themselves that codes of ethics develop purely in order to protect clients. If sociology is, as Berger suggests, the art of mistrust, then it is perhaps time that we were a little less trusting.

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19. Ibid., p. 73.
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46. This is a very general outline of a rather complex legal situation. For a more detailed examination of the legal status of the surgeon, see ibid., pp. 56-58.
50. Report from the select committee on medical registration, 1847, (602); First and second reports from the select committee on medical registration and medical law amendment, 1847-48, (702).
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56. In the College of Surgeons, general practitioners were excluded from the Council under a bye-law of 7 April 1748. See the First and second reports from the select committee on medical registration and medical law amendment, 1847–48, Q. 11. In the College of Physicians they were excluded under bye-laws of 1771, described in Sir George Clark, A history of the Royal College of Physicians, Oxford, Clarendon Press for the Royal College of Physicians, 1964–66, 2 vols., vol. 2, p. 566.


58. Physical violence was used, for example, by the licentiates of the Royal College of Physicians in their attempt to reform the College in the period 1767–1771. For a detailed analysis, see ibid.


60. Leake, op. cit., note 2 above, p. 76.

61. Ibid., pp. 93–94.

62. Ibid., pp. 117–118.


64. Ibid., p. 24.

65. Ibid., p. 27.

66. Ibid., p. 30.


71. Leake, op. cit., note 2 above, p. 97.

72. Ibid., p. 94.

73. Ibid., p. 92.

74. Ibid., p. 98.

75. Ibid., p. 106.

76. Banks, op. cit., note 8 above, p. 10.

77. Ibid., pp. 5–9.

78. Ibid., pp. 54–59.

79. Ibid., pp. 43–47.


81. The most striking similarities are, perhaps, to be found in the legal profession in the nineteenth century. As Carr-Saunders and Wilson have noted, the development of both professions "was anything but smooth . . . On reflection it appears that what happened in both cases was the early segregation of practitioners, advocates, and physicians, whose function at a later date was realized to be specialist. But the associations of these specialists, having attained great power and prestige, attempted to inhibit the development of general practitioners of law and medicine of whose services the public had need. When they could not prevent their appearance, they tried to keep them subservient, and the history of both professions is largely concerned with the problems so brought about." See Carr-Saunders and Wilson, op. cit., note 11 above, p. 304. In the legal profession the general practitioners were, of course, solicitors.

Competition and Monopoly in a Profession:
The Campaign for Medical Registration
in Britain

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Competition and monopoly in a profession
The campaign for medical registration in Britain

Ivan Waddington

The 1858 Medical Act is rightly regarded as a legislative landmark in the development of the medical profession in Britain, for it was this Act which established the General Medical Council, and which required the Council to maintain a register of duly qualified practitioners. It is, therefore, hardly surprising that the Act should have been the subject of a good deal of comment both by medical historians and, more recently, by a number of sociologists with a particular interest in the sociology of the professions. In general, two broad approaches to understanding the significance of the Act may be identified in the literature. The first of these, which may be regarded as the more traditional one, has emphasised the benefits of medical registration to the public, whilst the benefits accruing either to the profession as a whole, or to particular segments within the profession, have received relatively little attention. Thus, in a paper written to celebrate the centenary of the General Medical Council, A.P. Thomson argued that "the Council came into existence for the protection of the public" (1), whilst more recently, Dr. Poynter has suggested that "The important thing to remember is that the Act was not framed for the benefit of the profession (...) but was one designed to protect the people in their individual and corporate capacity" (2). It is, perhaps, not surprising to find a similar position echoed by the General Medical Council itself. Thus, in 1970, the G.M.C. pointed out that the preamble of the 1858 Act stated that it was "expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners", and went on to argue that "the whole of the Council's functions flow from that original objective
It can be said that the general duty of the Council is to protect the public, in particular by keeping and publishing the Register of duly qualified doctors (...)" (3).

In recent years, however, some social scientists have begun to develop a more sceptical analysis of the significance of registration. Thus, in their analysis of the rise of the medical profession, the Parrys have suggested that registration may best be seen as part of "an occupational strategy which is chiefly directed towards the achievement of upward collective social mobility and, once achieved, it is concerned with the maintenance of superior remuneration and status" (4). Thus, they argue, registration allows practitioners to achieve "a degree of monopoly with respect to the provision of particular types of services in the market place" (5). Perhaps the most detailed and systematic analysis of medical registration as a monopolization strategy, however, is contained in the work of Berlant, which revolves almost exclusively around this theme. Thus, he suggests that the 1858 Medical Act should be seen, along with such things as the development of medical ethics, as part of a much broader attempt at monopolization; the campaign for registration, he suggests, was designed to reduce competition from outside the profession, whilst the development of medical ethics had the effect of regulating competition within the profession (6).

Bearing these two contrasting perspectives in mind, it is the object of this paper to examine the doctors' lengthy campaign for medical registration in the middle years of the nineteenth century. On the basis of this examination, it will be suggested that doctors were by no means unaware of the relationship between registration and monopolization; nor were they unaware of the benefits - particularly in terms of the control of numbers entering the profession - which they stood to gain from registration. On the other hand, however, it will also be suggested that any attempt to see the campaign for registration simply in terms of a monopolization strategy necessarily involves considerable oversimplification. Thus it will be argued that the
campaign for registration was not simply an attempt to erect a legal barrier between the qualified and the unqualified, but that a central dimension of the campaign involved the attempt to restructure the relationships between different segments of the profession in such a way as to destroy the monopolistic privileges of the medical corporations. Thus, in an apparently contradictory manner, the campaign for registration simultaneously involved both monopolistic and anti-monopolistic elements. This apparent contradiction, it will be suggested, can be understood by analysing the campaign for registration within the context of the network of relationships both between different segments of the profession, and between qualified and unqualified practitioners.

The campaign for registration, as is well known, was an extremely long one; the bill which required a medical register to be compiled, and which finally received the Royal Assent on 2nd August, 1858, was the sixteenth (7) in a long line of bills on this subject, the first of which had been introduced in 1840. One reason for this lengthy delay before a bill was passed was that, as we shall see, different groups within the profession had radically divergent interests, and there was, therefore, violent disagreement within the profession as to what sort of bill was required. It is, however, interesting to note that there was no significant group within the profession which was opposed to the principle of registration as such, for although it was the general practitioners who were most vehement in their demands for a register, even the conservative Royal Colleges were not opposed to such a measure. Thus, in his evidence before the Select Committee on Medical Registration in 1847, the President of the College of Physicians, J.A. Paris, stated that the College had no objection to a register (8), whilst the College Registrar, Frances Hawkins, went considerably further, and expressed the view that it would be "very desirable that the medical profession should be registered in a manner better than it is now" (9). Henry Holland similarly argued that it was "desirable that the registration of medical men should be much more authentic and effective than it now is" (10). For the College of Surgeons, the President, William Lawrence, saw no objection to "a registration of medical practitioners that should set forth the qualifi-
cations under which they practise" (11), whilst Sir Benjamin Brodie, a member of the Council of the College, held that a system of registration of all medical practitioners "would be a very good thing; it would be popular with the profession, and rather useful for the public" (12).

There was, then, little disagreement within the profession on the desirability of registration. There was, however, major disagreement over what form that registration should take, and to understand the sources of this disagreement it is necessary to examine briefly the structure of medical practice during this period. The changing structure of the medical profession during the first half of the nineteenth century has been analysed in detail elsewhere (13), so that a brief summary is all that is required in this context.

As is well known, the structure of the medical profession had traditionally involved the differentiation of three separate occupational groups: physicians, surgeons and apothecaries. Each of these three groups had its own legally defined sphere of practice, and corresponding to these groups there were three major controlling bodies engaged in granting licences to practise medicine and surgery, namely the Royal College of Physicians, the Royal College of Surgeons (formerly the Company of Surgeons) and the Society of Apothecaries. Moreover, this tripartite structure was not simply a technical division of labour; equally importantly, it was a system of social stratification for, as Peterson has pointed out, the three orders of medical practice reflected "the social division of medical practitioners into three status groups or estates" (14).

However, during the early nineteenth century, due partly to changes in the demand for medical care associated with the Industrial Revolution, the traditional tripartite structure of the profession was steadily being eroded, and replaced by the modern professional structure, based on the differentiation between general practitioners and consultants. The development of general practice, however, proved to be the source of a good deal of intraprofessional
conflict. Thus the development of general practice necessarily served to undermine the traditionally rigid barriers separating the different branches of practice, for the work of the general practitioner involved, as the name implies, not only medicine and surgery, but also a good deal of midwifery, and generally pharmacy too. What was particularly significant in this development—and it was this which particularly disturbed the Royal Colleges—was that general practitioners were not only carrying out what had traditionally been regarded as high status medical work, but were also providing services such as those involved in midwifery and pharmacy, which the Royal Colleges saw as exclusively manual and trading operations, and therefore of low status. The Royal Colleges responded to this situation by trying to maintain the traditional barriers separating the different branches of practice, and by trying to inhibit the development of general practice, for they feared that the incorporation of manual and trading elements into the doctor's role threatened the high status which physicians had long enjoyed, and which surgeons had recently attained. Thus the Royal Colleges not only persistently refused to make provision for the type of education required for general practice, but, under the operation of their bye-laws, also excluded general practitioners from their governing Councils. General practitioners were thus denied any participation in the policy-making processes within the two most influential medical corporations. The situation of general practitioners within the medical profession was, as Peterson has noted, anomalous, for they were a "hybrid class" (15), for whom there was no recognised place within the traditional tripartite structure. Whilst general practitioners held licences from one or more of the medical corporations, there was "no corporation dedicated to safeguarding and advancing their interests and status. They were relegated to inferior positions within the corporations and neglected by their leadership" (16).

It is hardly surprising that general practitioners should have expressed their dissatisfaction with this situation, and throughout the first half of
the nineteenth century, they carried on a long struggle for a variety of medical reforms. Thus, amongst other things, they put forward demands for the democratic reform of the medical corporations, and for the reform of medical education. Increasingly, however, general practitioners came to see the maintenance of the traditional tripartite structure as the central source of many of their problems, for it was this, above all else, which was the stumbling block to their professional aspirations. Thus the general practitioner was neither physician, nor surgeon, nor apothecary, and as such there was not — nor could there be — any place for him within a professional structure which recognised only these traditional categories; only by breaking down these traditional professional divisions, and replacing them with ones which corresponded more closely to the newly emerging professional structure, could general practitioners hope to achieve clear recognition of what they held to be their rightful place within the profession. It was, therefore, of major importance to the general practitioners that any proposed system of registration should be one which served to break down, rather than to perpetuate, these traditional professional divisions. Thus one of the commonly expressed demands of the general practitioners was for a single register which would give all qualified practitioners a similar legal status, with the legal right to perform the complete range of medical and surgical tasks. The Royal Colleges, on the other hand, whilst not being opposed to the principle of registration, insisted that there should be not one common register for all practitioners, but rather three separate registers for physicians, for surgeons and for apothecaries; in this way, the traditional "orders" of the profession, each with its own exclusive, legally defined sphere of practice, would be maintained. Thus the general practitioners' demand for a common register can be seen as a genuinely radical demand, and one in which, as we shall see, the anti-monopolistic elements of the registration movement were most clearly revealed. Thus the demand for a single register was, in effect, a demand for the abolition of the tripartite structure, and for the dismantling of those legal
restrictions which were very much a part of that structure, and which were designed to reserve a particular kind of medical work for each of the three grades of practitioner. As such, it also represented an attack on the exclusive privileges and jurisdictions of the medical corporations, and an attempt to undermine the traditional status distinctions within the profession. Given this situation, it is hardly surprising that the high status groups within the profession - that is, the consulting physicians and surgeons who controlled the Royal Colleges - should have resisted what they saw as the "levelling principles" involved in the campaign for a common register.

The attitude of the Royal Colleges to the proposed plan for a common register can, perhaps, be best illustrated by reference to the evidence given by their spokesmen to the 1847 Select Committee on Medical Registration. The committee had been established shortly after Henry Warburton and Thomas Wakley, the radical editor of the Lancet, had introduced into the House of Commons a bill "For the Registration of qualified Practitioners", and much of the early evidence given by the Colleges' spokesmen related to this bill. One aspect of the bill which the Royal Colleges found particularly unpalatable was the fact that it made provision for the common registration of the three "orders" of the profession (17), with all qualified practitioners enjoying a similar legal status. Thus J.A. Paris, the President of the College of Physicians, held that the effect of the bill would be to create one class of medical practitioner. He argued that "the highest grade would cease to exist", with the result that medicine would no longer be a learned profession (18). Although not opposed to registration as such, Paris held that "medical men should be registered in classes or grades" (19). Frances Hawkins, the College Registrar, similarly held that "if the registration were to be formed upon the principle of their (the three orders of the profession) being placed together, it would tend to destroy those distinctions which have been found to be beneficial to the whole profession, and also to the public" (20). The effect of the bill of Warburton and Wakley, he
held, would be to "throw all the orders of the profession into one class (...) I think the attainments of those who have hitherto been the most highly educated in the medical profession would undoubtedly be lowered" (21). George Burrows, Senior Censor of the College of Physicians stated that "I should be more content with the present state of things than have this Registration Bill passed as it stands, because I feel convinced in my own mind that it would revolutionize and disorganize the profession, and that it would degrade our profession" (22). Henry Holland held that the bill of Warburton and Wakley was "pernicious" (23); it was, he argued, "exceedingly important for the profession and the public that there should be grades in the profession, and that any measure that might tend to abolish those grades, or even to weaken their influence, would be as injurious to the public as to the profession" (24). The physicians' concern to maintain a rigid barrier between themselves and the "lower orders" of the profession was, perhaps, most clearly expressed by the President of the College in relation to something which, to the modern reader, might seem a trivial change in the legal status of the physician but which, to the College, was clearly of considerable importance. For a number of years, both surgeons and apothecaries had had the legal right to sue a patient for recovery of charges. However, physicians, as befitted gentlemen, were considered, as far as the law was concerned, as attending patients for a honorarium, and as such, they were unable to maintain an action for fees. The bill of Warburton and Wakley, however, proposed to extend to all registered practitioners the right of recovering payment of charges for their attendance. The Royal College of Physicians was, as ever, alert to any threat to its exclusive status, even from such a minor change in the law. "We object to that very much", said their President, "we consider that the physician would under those clauses be converted into a tradesman; we should feel that we had lost caste by allowing those clauses to pass" (25).

Like the College of Physicians, the Royal College of Surgeons also objected to any proposed form of
registration which did not clearly differentiate between the high and low status groups within the profession, for the consulting surgeons, like the physicians, were equally keen to preserve their exclusive status against the threat of the parvenu group of general practitioners. Thus William Lawrence, the President of the College of Surgeons, criticized "those levelling principles of equality which are found to be injurious wherever they exist in practice" (26), and he went on to argue that "If you have all on one level, it must be by depressing those who are higher to the level of those who are lower in public opinion and confidence" (27). Lawrence considered that a registration in classes or grades would be "the only kind of registration which would give the public proper information" (28). Sir Benjamin Brodie similarly held that the bill of Warburton and Wakley would tend to "confound all grades of the profession together", a process which he held to be "not at all desirable" (29). George James Guthrie, a Councillor and former President of the College of Surgeons did not object to a register of qualified practitioners, but he held that "they should be kept distinct as to their being physicians or surgeons, or surgeon-apothecaries" (30). Using a particularly appropriate medical analogy, he went on to argue that "a certificate would say the individual is qualified to practise as a surgeon or as a physician, or a general practitioner as the case may be; but it does not do so, and that is what the Colleges have objected to, as pounding us all up in the same mortar, in fact" (31).

Quite clearly, one consequence of the reform movement within the profession was the polarisation of general practitioners and consultants into opposite camps, for whilst the general practitioners were intent on the abolition of the tripartite structure, the consultants had an equally strong vested interest in maintaining that structure. Moreover, the very considerable prestige and influence of the Royal Colleges enabled them to effectively resist, for many years, all the general practitioners' demands for reform. However, the task of defending the traditional institutional structure was becoming increasingly difficult, for the tripartite structure was, in effect, based on a complex system of monopolies and restrictive
practices which were becoming increasingly un­
acceptable within the context of mid-nineteenth
century politics. Thus there were separate laws
relating to physicians, to surgeons and to
apothecaries, the explicit purpose of which was
to reserve a particular branch of medical practice
for a particular grade of practitioner. In addition,
some of the medical corporations enjoyed legally
defined monopolies within certain geographical
limits. Thus it had long been illegal for anyone
except Fellows and Licentiates of the College of
Physicians to practise as a physician within Lon­
don and for seven miles around; by this regulation,
many highly educated medical graduates of Scottish
and continental universities were excluded from
practice in London, where of course, the most
lucrative practices were to be found.

Of rather greater importance, however, since it
affected many more practitioners, was the monopoly
which had been granted to 'the Society of Apothe­
caries by the Apothecaries' Act of 1815. Most
general practitioners had long been in the habit
of dispensing medicines for their own patients and,
indeed, in country districts and small towns, where
there was a minimal division of labour within the
profession, this practice was almost universal.
However, the Act of 1815 made it illegal for anyone
to practise as an apothecary in England or Wales
without having first obtained the licence of the
Society of Apothecaries; thus all those who wished
to engage legally in general practice were obliged
to become licentiates of the Society.

The Apothecaries' Act had, as Holloway has noted,
"a closer affinity to a Stuart patent of monopoly
than to a statute in the age of 'laissez-faire'",
and the major effect of the Act was "to maintain
the ancient hierarchical structure of the medical
profession and the apothecary's inferior status
within it" (32). Thus the society sought to enforce
its monopoly not only against wholly unqualified
practitioners, but also against physicians and
surgeons in general practice. In 1833, for example,
a Scottish educated physician was convicted for
illegally practiseing as an apothecary and, following
this conviction, the Society of Apothecaries sent
threatening letters to Scottish graduates in general practice, insisting on their acquiring the Society's licence (33). In his evidence before a Select Committee in 1848, the solicitor to the Apothecaries' Society admitted that whilst he was not aware of any prosecution against a chemist for practising as an apothecary, the Society had prosecuted a number of members of the College of Surgeons (34).

The requirement that all general practitioners be licensed by the Apothecaries' Society understandably caused a great deal of resentment on the part of many general practitioners, for the association between Apothecaries' Hall - or "Rhubarb Hall", as the Lancet called it - served simply to emphasize the inferior status of the general practitioner within the profession. "While the consulting physician and surgeon could claim to be members of Royal Colleges, the general practitioner was associated by law with a London trading company" (35). The issue was nicely summed up by one contemporary observer who remarked that "It does not seem quite so reasonable, that, because the apothecaries have ceased to be grocers, they should be forthwith invested with the entire regulation of the practice of medicine in England" (36).

The intention behind the granting of these monopolies had, of course, been to confine practitioners to a particular branch of medicine or surgery, and thus to maintain the traditional tripartite structure. As such, the chief sufferers from the operation of these monopolistic practices were the general practitioners, a point which the Lancet was not slow to note. Thus, in an editorial on the medical corporations, the Lancet noted that as a result of the passing of the Apothecaries' Act, "a state of things has resulted which is entirely without parallel. Various have been the persecutions with which unprincipled power has tormented its victims. There have been religious persecutions, and political persecutions, and literary persecutions, and scientific persecutions; but the general practitioners of England are the first men who have groaned under a rhubarb perse-
cution, - most nauseous and disgusting" (37).

In addition to the monopolies which had been granted to individual medical corporations there were other monopolistic practices within the medical profession which also gave rise to a good deal of resentment on the part of general practitioners. Thus, as has been briefly noted already, in a vain attempt to stem the rise of the general practitioner, both Royal Colleges had, under the operation of their bye-laws, excluded general practitioners from their governing Councils, thus concentrating power in the hands of the consultants. The situation of general practitioners within the Royal Colleges was accurately summed up by the observation of James Bird that "neither the College of Surgeons nor the College of Physicians has any sympathy with the general practitioners; the interests of that body have at all times been placed in abeyance, and for want of a recognised position they have hitherto been disregarded in all communications with the Government". The result of the general practitioners' exclusion from the Councils of the Colleges was that "there is no body, no head, to represent the interests of nine-tenths of the profession" (38).

Given that monopolies of all kinds were increasingly coming under attack during this period, it is not surprising that, in seeking to undermine the tripartite structure, the general practitioners and their parliamentary allies should have emphasised the monopolistic character of the institutions against which their attack was directed. Thus, in an editorial in 1832, the Lancet suggested that "The preamble of the Apothecaries' Act ought, in consistency with its general tone and spirit, to have run, - 'Whereas, it is expedient to grant a monopoly to the Apothecaries' Company', - for there is scarcely a clause in the act which is not framed with a view of putting money into the pockets of these incorporated tradesmen" (39). Two years later, in the parliamentary debate in which Warburton moved for an enquiry into the medical profession, one M.P. pointed out that the Apothecaries' Act "operated only as a most injurious monopoly", and he went on to add that "At a period when Government
was putting an end to all monopolies, it was singular, that the monopoly of mind alone should remain" (40). In the same debate, another M.P. called for the abolition of what he termed the "ungenerous and selfish" monopoly of the College of Physicians in London (41). Shortly after the Select Committee of Enquiry had been established, the licentiate of the College of Physicians presented two petitions to Parliament, listing their grievances. In the first of these, they claimed that "the fellows have usurped all the corporate power, offices, privileges, and emoluments, attached to the college" by the operation of a series of "invidious bye-laws, made in the spirit of corporate monopoly", whilst the second petition complained that the system of choosing the members of the council of the College "is framed on a close and narrow system of monopoly and exclusion, exhibiting some of the worst features of a close corporation" (42).

By the early 1840's, the monopolistic privileges of the medical corporations had become a consistent target of attack by the general practitioners. Thus in 1842, the Lancet, a consistent campaigner on behalf of general practitioners, asked "Is it not true that even the multitudes of all civilised nations are raising their voices against monopolies in trade and commerce?" The fact that monopolies continued to exist within the medical profession was, said the Lancet, a "thousand times more baneful and detestable" (43). In 1847, when it became known that the Royal Colleges were opposing the bill of Warburton and Wakley, discussed earlier, a group of practitioners in Cirencester petitioned Parliament expressing their view that "the said colleges etc. (an irresponsible few) are endeavouring to hold to themselves, as heretofore, an usurping and monopolizing power, for their own selfish and exclusive interests, without regarding the best interests of the profession or public" (44). Equally importantly, the attack on the medical corporations continued from within Parliament. Thus, on the second reading of Cowper's bill, which eventually became the Medical Act of 1858, one M.P. claimed that what was required was a bill "to repeal all Acts hitherto passed which had given a
monopoly to the body of physicians in London, and
placed restrictions upon the other branches of
the profession" (45), whilst the radical M.P.,
Tom Duncombe, held that the monopoly of the College
of Physicians was "a nuisance to everybody in
London and seven miles around" (46).

Clearly discernible within many of the reformers'
comments was the anti-monopolistic sentiment of
laissez-faire ideology. Sometimes, however, general
practitioners drew on laissez-faire ideology in a
much more detailed and explicit way in order to legiti-
mate their opposition to the tripartite structure.
A particularly clear example of this was provided
by a series of articles published by the *Lancet*
on "the real and imaginary grievances of the
medical profession" (47). The author of these
articles, D.O. Edwards, argued that "the mainspring
of everything great or useful in medicine and its
collateral arts, is, and ever has been, private
enterprise" (48), and he went on to argue, in an
almost classical statement of laissez-faire
philosophy, "that no restraint ought to be placed
on the liberty of the subject which is not clearly
and unequivocally conducive to the public
benefit. From this principle it is deducible, that that
government is the best which attains its object
with the fewest restrictions" (49). This principle
should, he suggested, also be applied to the
government of the medical profession: "For my part
I have such a horror of monopoly and exclusiveness
in every shape, that I would carry out this
liberating principle to its utmost limits, and I
would make it the Ithuriel test by which the
genuineness of every plan of reform should be
determined" (50). Amongst the major grievances of
the general practitioners were, said Edwards, "the
bonds and shackles which monopoly had forged"
(51), the effect of which had been "to impede and
smother" enterprise in medical practice, and to
"shackle the free agency and lessen the usefulness
of the medical man" (52). Edwards bitterly criti-
cised what he called the "capricious and forcible
arrangement of the medical profession, into three
different classes" (53) and in a clear reference
to the Royal Colleges, he pointed out that amongst
the major opponents of reform were "the monopolists,
who oppose the removal of those restrictions which "cabin, crib and confine" the profession" (54). What was required by way of reform was "the emancipation of the profession from the restraint of all unjust and unnecessary laws" (55). What Edwards was asking for, amongst other things, was the removal of those restrictions which confined medical men to one particular branch of practice, for all practitioners would then be able to compete on equal terms. What the commonalty of the profession were demanding, he said, was "'a clear stage and no favour' for the enterprise of all" (56), a statement of laissez-faire philosophy which was subsequently echoed in Parliament when one M.P. argued that the medical profession should be given "a fair field and no favour" (57).

Quite clearly, any attempt to see the general practitioners' campaign simply in terms of a monopolization strategy necessarily involves considerable oversimplification for, as we have seen, the campaign involved from the very beginning a clear attempt to undermine the monopolistic privileges and exclusive status of the Royal Colleges. Moreover, when a registration bill was finally passed, it represented at least in some, if not in all, respects, a considerable triumph for the general practitioners. Thus the 1858 Medical Act required the names of all qualified practitioners, whatever their legal status prior to the Act, to be entered in a common register, rather than in three separate registers, as the Royal Colleges had wanted; all registered practitioners were thus accorded the same legal status. As Holloway has noted, the 1858 Act "thus ended the rigid hierarchical division of the profession into three estates" (58), for the Act was not framed around the maintenance of the separate privileges of physicians, surgeons and apothecaries, but around the common status and common privileges of all registered or "duly qualified" practitioners.

The Act thus effectively ended the tripartite structure, with its monopolistic restrictions designed to confine practitioners to one particular branch of practice (59). It also abolished all regional monopolies, like that of the Royal College
of Physicians in London, for under clause 31 of the Act, all registered practitioners were given the right to practise "in any Part of Her Majesty's Dominions". Under the same clause, Scottish graduates, many of whom had been practising under the continual threat of prosecution by the Society of Apothecaries, were also given the legal right to practise in England and Wales without having to take out a licence from one of the English corporations. Thus, the network of legal restrictions which had served to "cabin, crib, and confine" the profession was finally removed.

What has been said above should not be taken as an indication that the 1858 Act represented an unqualified victory for the general practitioners for, as Newman has pointed out, there were a number of aspects of the Act with which general practitioners were dissatisfied (60). However, what is important within the present context is that the general practitioners' campaign was largely directed against, and was largely successful in getting abolished, a number of longstanding monopolistic restrictions within the medical profession. Moreover, it is, of course, precisely this aspect of the registration movement which is missed if one regards the campaign for registration simply as a monopolization strategy.

The major problem with any framework such as that adopted by Berlant and the Parrys is that it appears to be premised on the assumption of a unified profession with a common interest which is best served by registration. Such an assumption is not altogether invalid; it may be useful, for certain purposes, to see the medical profession as a group with a common interest in, for example, excluding unqualified practitioners, though even here, as we shall see, there were significant differences between general practitioners and consultants. For other purposes, however, such an assumption is wholly misleading. Thus the medical profession in the mid-nineteenth century was not a unified profession; indeed, it was, as Dr. Poynter has noted, "a profession in chaos (...) split from top to bottom by jealous rivalries and competing interests" (61). The profession consisted, prior
to 1858, of a number of separate occupational groups, each with its own distinct legal status, its own distinct system of education and, most importantly, its own distinct occupational interests. As such, the campaign for registration was concerned at least as much with the restructur- turing of relationships between different segments of the profession as it was with excluding the unqualified from practice, and it is, of course, in the former aspects of the campaign that its anti- monopolistic elements can most clearly be seen.

However, as has already been noted, the campaign for registration simultaneously involved both anti- monopolistic and monopolistic elements. Thus the campaign sought not only to destroy the monopolistic privileges of the medical corporations, but also to restrict entry into the profession, and to exclude the unqualified from practice. It is to an examination of these monopolistic elements of the campaign that we must now turn.

In the early 1830's, the Lancet argued that "the members of the medical profession are not a body of wealthy individuals" (62), and there is, indeed, considerable evidence to indicate that whilst the incomes of consultants were often very high, many general practitioners were forced to live on extremely modest incomes (63). The two most frequently identified causes of what medical practitioners saw as the depressed level of medical incomes were, firstly, that there was an oversupply of qualified practitioners, and secondly, that qualified practitioners had to face unfair competition from those who were not qualified. Thus, in relation to the first point, the Lancet held that one reason why so few practitioners earned what it called "the paltry sum of 500 £ (pounds) per annum" was that "the colleges are tempted by their charters to admit such a number of practitioners, that sufficient rewards cannot be afforded to them" (64). The evils of excessive competition, arising from an oversupply of qualified practitioners, were also pointed out by the author of an article which was published anonymously in the Quarterly Review in 1840. Thus the author - believed
to have been Sir Benjamin Brodie - argued that "the supply of medical practitioners is in fact not only very much beyond the demand, but very much beyond what is necessary to ensure a just and useful degree of competition (...) and to this cause may mainly be attributed the present restless and uneasy state of the profession. In this, as in all other pursuits, a certain degree of competition is required for the security of the public; but in the medical profession it is easy to conceive that the competition may be not only beyond what is really wanted, but so great as to be actually mischievous" (65). Moreover, the view that the profession was overcrowded was not one which was confined to medical practitioners. Thus in the debate on the second reading of his registration bill in the House of Commons in 1858, William Cowper held that "at present there were more young men entering the profession than could gain a livelihood by it" (66), whilst, as Musgrove has pointed out, the term "overcrowded professions" was freely applied to both the medical and legal professions in vocational handbooks of the period (67).

Whether the profession really was overcrowded, however, is something which is extremely difficult to determine with any precision, not least because there was no official register prior to the 1858 Medical Act. There were certainly many contemporary complaints of overcrowding, though as Perkin has noted, these should be treated with caution, since such complaints were almost as old as the professions themselves (68). On the other hand, however, Peterson is in no doubt that the profession was overcrowded. Thus she argues that one reason why medical men, particularly those in public employment, salaried posts, and sick clubs, were so dependent on their lay employers was "because of the overcrowding of the profession and the consequent competition among medical men for practice wherever it could be found" (69). Whether the profession was or was not overcrowded, however, it is clear that the belief that it was overcrowded was widespread amongst contemporary medical men. Moreover, it is equally clear that any restriction of entry to the profession could only affect medical incomes in an upward direction, and thus
could only be advantageous, in a pecuniary sense, to medical practitioners. The effect of restricting entry to the profession had, in fact, been dealt with by no less an authority than Adam Smith, in a letter which he had written to William Cullen in 1774. Cullen, who was at that time President of the Royal College of Physicians of Edinburgh, had written to Smith asking for his views on the practice of some Scottish universities of selling medical degrees, often without requiring any residence. In his reply, Smith criticized those institutions for taking part in what he called "a most disgraceful trade" in degrees, but he went on to point out that the "facility of obtaining degrees, particularly in physic, from those poor universities, had two effects, both extremely advantageous to the public, but extremely disagreeable to the graduates of other universities, whose degrees had cost them much time and expense. First, it multiplied very much the number of doctors, and thereby no doubt sunk their fees, or at least hindered them from rising so very high as they otherwise would have done. Had the universities of Oxford and Cambridge been able to maintain themselves in the exclusive privilege of graduating all the doctors who could practise in England, the price of taking a pulse might by this time have risen from two or three guineas, the price which it has now happily arrived at, to double or treble that sum (...) Secondly, it reduced a good deal the rank and dignity of a doctor" (70).

The effect of monopolistic practices on price levels was, of course, widely appreciated in the nineteenth century, and it is clear that the logic of Adam Smith's argument was not lost on the medical profession. Thus the Lancet held that "It is admitted on all hands that many of the evils under which the medical profession now labours, are owing to the teeming multitude of practitioners. This necessarily involves an impoverished state of the profession, and has, doubtless, contributed largely to that depression of intellect and morals among its members (...) The means of restraining this superfluity of doctors, and rendering the number of the profession more proportionate to the population, become, therefore, very important
objects of medical legislation". The Lancet then went on to review a number of schemes for restricting entry to the profession, including the imposition of a direct numerical limitation, a plan which was rejected as being "incompatible with the institutions of a free country, and extremely difficult to reduce to practice under any circumstances". Eventually, the Lancet argued that the best way to restrict entry was by "making the standard of qualification high, as well in medicine as in letters and science". If this scheme were adopted, "the numbers of the profession would be effectually limited without any injurious exclusions; the character of the profession would be greatly elevated, and the public welfare would be promoted" (71). It is interesting to note that the Lancet's ideas were echoed almost exactly by William Cowper when he sought leave to introduce his bill which, it should be remembered, subsequently passed into law as the 1858 Medical Act. Thus Cowper argued that the standard of qualification for medicine was too low, and that his bill sought to establish an adequate minimum standard. "If the low standard were raised", he argued, "benefit would be obtained by more skilful treatment, and to the profession by reducing the competition of those who underbid one another from the want of remunerative practice" (72). These were, of course, relatively sophisticated statements of what was essentially an economic argument for restricting entry to the profession; the rather less sophisticated form of this argument was neatly expressed by a correspondent of the Lancet who pointed out, albeit rather bluntly, that "a fair system of undisputed remuneration" depended upon "an effective system of registration" (73). There can, in fact, be little doubt that one dimension of the campaign for medical registration involved a quite conscious attempt on the part of medical practitioners to restrict entry to the profession; nor can there be much doubt that practitioners were fully aware of the likely effect of this on the level of their own incomes. It is difficult to disagree with Musgrove's comment that the "movement towards registration and the stipulation of minimum training requirements is an indication of a felt need to restrict entry" (74) and, as we shall see later,
there is some evidence to suggest that the 1858 Act met this felt need very adequately.

The other aspect of the campaign for registration which involved a clear element of monopolization was, of course, the attempt to prevent unqualified practice, and here, once again, economic considerations were of major importance. Thus in 1843, the *Lancet* argued: "That 'the profession is overstocked' we daily hear exclaimed, and the assertion is true. The 'profession' is overstocked, and with a superabundance of unqualified men, mere speculators in drugs and chemicals". The result was that "educated practitioners are deprived of their legitimate means of obtaining a subsistence". Medical men, continued the *Lancet*, "who scorn to make their liberal profession a trade, complain of this usurpation of their rightful field of profit, and of this degradation of medicine, in vain" (75).

A few years later, a petition in favour of the 1847 bill of Warburton and Wakley, discussed earlier, held that "a very grievous injury is inflicted upon those members of an honourable profession who have complied, at a great cost, both of time and money, with the provisions of the law, and the regulations of the Colleges and Examining Boards, but who are now left without adequate protection in the exercise of their profession" (76). The view that medical education was an investment, and that unqualified practitioners were denying the qualified a legitimate return on that investment was, in fact, a recurrent theme. This idea was, for example, very precisely expressed by one contributor to the *Lancet*, who held that "no person should risk the expenditure of time, labour and money necessary to the attainment of his qualification of licence to practise, unless he felt himself to be effectually guarded by the laws against the competition of unlicensed and ignorant, though impudent and plausible empirics" (77).

Whilst demands for the suppression of unqualified practice were almost invariably accompanied by the claim that unqualified practitioners were taking income away from those who were qualified, these purely economic arguments were sometimes coupled with other arguments relating to the
protection of the public; indeed the profession had
to put forward arguments of the latter kind if it
hoped to persuade the legislature to grant a
monopoly of practice to those who were qualified.
Thus, the contributor to the *Lancet*, cited above,
argued that if unqualified practice were made
illegal, this would not only secure "the rights
and privileges of medical men", but would also
serve to protect "the public health" (78). The
purely scientific arguments in favour of limiting
practice to the qualified were not, however, very
strong. Thus, as Peterson has pointed out, much
of the available medical treatment was of
questionable value, even by the standards of the
day (79), whilst what little authority medical
men had "came not from their medical knowledge
but had its origins in connection, social origins,
or social style" (80). Most importantly, however,
medical men themselves, as Peterson has correctly
noted, "seemed to see the issue more in terms of
protection from competition than in terms of the
superior claims of medical science" (81).

In demanding protection from competition, the rank
and file of the profession was, of course,
wanting what was in effect the creation of a
new monopoly, although most practitioners were
understandably reluctant to express their demands
in those exact terms. Indeed, Edwards, in the
series of articles referred to previously, attempted
to defend the profession against such charges. Thus
he criticised "a belief too prevalent in society,
that the medical professions are a sordid exclusive
caste, who seek by vexatious barriers and invidious
distinctions to secure a monopoly of the healing
art" (82). A "monopoly of the healing art" was,
however, precisely what the rank and file of the
profession was seeking, and it was in relation to
this demand that a clear split emerged within the
profession itself.

Whilst there were, doubtless, some unqualified
practitioners who made a handsome living by
practising amongst the middle and upper classes,
there was considerable agreement amongst contem­
porary observers that the great majority of un-
qualified practitioners were practising amongst
the lower classes of mid-Victorian society (83). Nor is this particularly surprising, for it was, of course, these people who had the greatest difficulty in paying even the relatively modest fees of the general practitioner; as one M.P. observed in the debate on Sir James Graham's bill in 1844, it was primarily the poor "who were in the habit of asking the druggists to prescribe, in order to avoid the expense of a doctor" (84). As such, it was, of course, the incomes of general-practitioners which were most affected by the competition of unqualified practitioners, for they were often competing for the same market amongst the ranks of both industrial workers and rural labourers; by contrast, consultants normally drew their private patients from the higher social classes, and hence their practices, and their incomes, were much less affected by the activities of unqualified practitioners. Thus, to the extent that unqualified practitioners were taking income away from those who were qualified, it was the general practitioners, rather than the consultants, who suffered.

This difference between the everyday work situations of general practitioners and consultants was of major importance in shaping the attitudes of these two groups towards the question of whether or not qualified practitioners should be given a legal monopoly of practice. Not surprisingly, it was the general practitioners who were most vociferous in their demands for the imposition of legal penalties for unqualified practice. Thus, for example, one of the reasons why general practitioners opposed Sir James Graham's bill of 1844 was because it did not make unqualified practice illegal (85). Thomas Wakley, defending as ever the interests of general practitioners, told the House of Commons that "it was the paramount duty of that House to prevent any person from practising who was not duly qualified", and he begged Graham "to listen to the petitions of the medical practitioners themselves" (86).

Consultants, on the other hand, as Peterson has noted, "had little interest in the control of unqualified practice, inasmuch as it had little
effect on their positions, prestige, or practice" (87), and they were, accordingly, able to adopt a less punitive attitude towards unqualified practitioners. Thus, in the article believed to have been written by Sir Benjamin Brodie, and published in the Quarterly Review in 1840, the author argued against giving a legal monopoly of practice to those who were qualified. The question to be decided was, he said, "Should those who have passed their examination, and received their licence, have a monopoly of practice? Should there be penal laws to prevent their being interfered with by the competition of the ignorant, the uneducated, and unlicensed? Or is it sufficient that the public are supplied with a list of those who are supposed to be qualified practitioners, it being then left to individuals to procure medical assistance where they please?" (88) He recognised that it was "natural that licensed practitioners, who have expended considerable sums of money, and no small portion of their lives, in their education, should be jealous of the competition of others" (89), and he also recognised that it was not so much consultants as "those who belong to the class of general practitioners, that require the especial attention and protection of the legislature" (90). Nevertheless, he was firmly of the opinion that the profession ought not to seek legislation to suppress unqualified practice; the "empire of opinion", he held, "will do more than legislative enactments" (91).

Such arguments found no sympathy amongst the rank and file of the profession, some of whom pointed out in no uncertain terms the difference between their own social situation and that of consultants. Thus, referring specifically to the article in the Quarterly Review, one practitioner wrote that "Court physicians and surgeons are better acquainted with the avenues of palaces than the thresholds of cottages. They are utterly ignorant of the kind of practice which is witnessed in rural districts and in poor neighbourhoods". If they had more knowledge of such things, claimed the writer, "they would not talk so coolly of 'leaving quacks to their fate'. As it is, the fate of the pretender is often much better than that of the genuine therapist" (92).
Another correspondent of the *Lancet* pointed out, in very sarcastic tones, that the London consultants who controlled the Royal Colleges had never supported the campaign to make unqualified practice illegal. "On this point", he said, "the Colleges have never sympathized with us; they do not — they will not. They affect not to believe in the existence of the evil: Cruikshank's caricature of the well-fed flunkies lazily asking, 'What are taxes?' might with equal fidelity represent two or our wealthy self-elected rulers asking one the other, 'What are quacks?'" (93)

Despite all their efforts, however, the general practitioners' campaign to have unqualified practice declared illegal was, in the end, unsuccessful, perhaps partly because the campaign received no support from the Royal Colleges, but also because, as Cowan has pointed out, the House of Commons regarded anything which smacked of monopoly with a good deal of suspicion (94). Thus whilst the Medical Act of 1858 made it an offence for any person to "wilfully and falsely pretend to be" a qualified or registered practitioner, it did not make unqualified practice as such illegal. The Act did, however, create a monopoly of practice for registered practitioners in all public institutions. Thus no unregistered practitioner was to be allowed to hold any appointment as a medical practitioner in the army or navy, or in "any Hospital, Infirmary, Dispensary, or Lying-in Hospital, not supported wholly by voluntary contributions". In addition, unqualified practitioners were excluded from holding any appointment in "any Lunatic Asylum, Gaol, Penitentiary, (...) Parochial or Union Workhouse or Poorhouse, Parish Union, or other public Establishment"; nor were they allowed to hold any medical appointment "to any Friendly or other Society for affording mutual relief in Sickness, Infirmity, or old Age, or as a Medical Officer of Health" (95).

Although many general practitioners were dissatisfied with the fact the the 1858 Act did not make unqualified practice illegal, the exclusion of unqualified practitioners from all government medical services was, in the medium and long term,
to assume greatly increased importance with the continual expansion of the public sector of health care in the late nineteenth and twentieth centuries. Thus, as Carr-Saunders and Wilson pointed out in 1933, the effect of the National Insurance Act of 1911 was to "very substantially" increase the value of registration, for the 1911 Act directed that only registered practitioners could be accepted on the medical list (96). Moreover, although the 1858 Act did not, except in the area of government services, create a legal monopoly of practice for those who were qualified, it did impose certain disabilities on unregistered practitioners. Thus unregistered practitioners could not certify any statutory documents, and they were not entitled, as were registered practitioners, to recover at law any charges for medical services which they may have rendered. In addition, as Berlant has noted, the Act also conferred an advantage on registered practitioners "by providing them with apparent state approval; that is, the prestige of the state was thrown behind members of the organized profession" (97).

In conferring these advantages on those who were registered, the Act followed closely the principle laid down by Sir James Graham in 1844, when he argued that the law should not be used to prohibit unqualified practice, but it should be used to "discourage it by securing exclusive advantages to the regular practitioner" (98). Thus the effect of the 1858 Act was not only to exclude unregistered practitioners from the steadily expanding public sector of medical care but also, in the private sector, to give registered practitioners what Berlant has described as "a competitive advantage in the open market" (99). Moreover, the competitive advantages enjoyed by registered practitioners were, like the monopoly of government service, to become increasingly important, so that the long term effect of registration was to create what became virtually a de facto, if not a de jure, monopoly of medical practice for registered practitioners.

If, however, these competitive advantages accruing to registered practitioners were to become more
apparent with the passage of time, the impact of the 1858 Act on the level of recruitment to the profession appears to have been one which took effect almost immediately. As we have seen, one reason why many medical practitioners supported the campaign for registration was because they were concerned about overcrowding within the profession, and they hoped that registration would make it possible to restrict entry to the profession more effectively, thus reducing overcrowding and excessive competition between practitioners. Moreover, there is reason to believe that the Act had precisely this hoped for effect. Thus, in the twenty years or so following the passage of the Act, the growth in the number of medical practitioners in England and Wales was quite minimal, and was far outstripped by the growth of the total population. In 1861, there were 14,415 medical practitioners in England and Wales. In the decade from 1861-1871, this number increased by just 269, or 1.8%, and in the period from 1871-81, there was a further increase of 407, or 2.7% (100). Thus, over the twenty year period from 1861-1881, the number of medical practitioners in England and Wales increased by under 5%, compared with a 24% increase in the employed male population, and an increase in the total population of no less than 29% over the same period (101). In the two decades following the 1858 Act, there was therefore, a marked reduction in the provision of qualified medical care to the population. In 1861, there was one medical practitioner for every 1392 persons, or 7.1 doctors per 10,000 population; by 1871 this had been reduced to one practitioner for every 1547 persons, or 6.4 doctors per 10,000 population, and by 1881 there had been a further reduction to one doctor for every 1721 persons, or 5.8 doctors per 10,000 population (102). It is true that in the two decades from 1881-1901 there was a considerably more rapid expansion of the profession, perhaps partly due to the fact that by the late 1870's and early 1880's there was a clearly recognised shortage of doctors, but as late as 1911 there were still fewer medical practitioners in relation to population than there had been fifty years previously (103). What is particularly
pertinent within the context of the present argument, however, is that a situation which was generally recognised as being characterised by a surplus of doctors prior to the 1858 Act had, within two decades of the passing of the Act, become one in which there was a serious shortage of qualified practitioners. Thus in his Carmichael Prize essay of 1879, Walter Rivington drew attention to "the decrease in the supply of medical men", and he pointed out that William Farr, who was at that time Superintendent of the Statistical Department in the Registrar General's Office, had also expressed his concern that qualified medical care had become steadily less available; indeed, Farr held that the shortage of medical practitioners was such that there was "an imminent danger" that qualified medical care might become "quite inaccessible to vast numbers of people" (104).

The shortage of qualified practitioners was also an issue which concerned the 1882 Royal Commission which had been appointed "to Inquire into the Medical Acts", and some of the evidence which was submitted to the Commission makes it quite clear that the \textit{Lancet} had not been mistaken when, many years previously, it had quite openly argued that the most effective way to restrict entry to the profession was "by making the standard of qualification high". Thus Professor Humphry, the Professor of Anatomy at Cambridge University, noted that medical men had "decreased in number relatively" (105), and he agreed that there was a "danger of the examinations becoming too strict" (106). He pointed to the "greatly increasing proportion of rejections" of candidates for a licence to practise medicine, a proportion which had increased from 14 per cent in 1867 to 23 per cent in 1875 (107). Asked directly whether he felt that "this increasing stringency of examinations has interfered with the public interest by diminishing too much the supply of medical men", Humphry replied "I believe it is so to some extent. When the examinations were increased, after the recommendations of the General Medical Council (...) were adopted, there was a sudden diminution of members in the profession" (108). The link between the 1858 Medical Act and the subsequent shortage of qualified practitioners
could not have been made more explicit. The Act had proved to be, as most practitioners had hoped it would, a most effective way of restricting entry to the profession.

In this case study of the campaign for medical registration in Britain, attention has been focused on the fact that the campaign involved both anti-monopolistic and monopolistic elements. The development of these apparently contradictory elements, it has been suggested, can be understood by analysing the campaign for registration within the context of the network of relationships both between different segments of the profession, and between qualified and unqualified practitioners. Thus the structure of relationships between consultants and general practitioners gave rise to an attempt by general practitioners to undermine the monopolistic privileges of the Royal Colleges, whilst the competitive relationships between qualified and unqualified practitioners, as well as the attempt to reduce competition amongst those who were qualified, gave the campaign its monopolistic elements. From this analysis it is clear that doctors - and in particular, general practitioners, who provided the major impetus for the campaign for registration - were in principle neither opposed to, nor were they in favour of, monopolies as such; rather, their attitudes towards medical monopolies varied depending on the way in which the operation of any particular monopoly affected their own social and economic situation both within the profession and in the wider society. Finally, it is hoped that this analysis, by bringing out some of the complexities of the campaign for registration, has shown that those writers who have seen the campaign simply as a monopolistic strategy have ignored the very clear anti-monopolistic elements of the campaign, whilst those writers who have argued that the 1858 Act was passed for the benefit of the public have traditionally ignored not only the fact that the profession derived monopolistic advantages from registration, but also that these potential advantages were clearly recognised within the profession from the very beginning of the campaign.
Notes
7. A seventeenth bill was subsequently introduced by the radical M.P.'s Buncombe and Butler.
8. Report from the Select Committee on Medical Registration, 1847, (620), Q. 87.
9. Ibid., Q. 1186.
10. Ibid., Q. 1478.
11. Ibid., Q. 1576.
12. Ibid., Q. 2031.
15. A Few Words on the Fellowship, with a Suggestion Concerning the Present Crisis, addressed to the President and Council of the Royal College of Surgeons of England by an Old Member of the College, London, Churchill, 1845, pp. 17 and 19, cited in Peterson, op. cit., p. 22.
17. The bill of Warburton and Wakley provided for a separate register for each of the three kingdoms, but not for a
separate registration for each of the "orders" of the profession.

19. Ibid., Q. 89.
20. Ibid., Q. 1146.
22. Ibid., Q. 575.
23. Ibid., Q. 1462.
24. Ibid., Q. 1463.
25. Ibid., Q. 104.
26. Ibid., Q. 1650.
27. Ibid., Q. 1695.
28. Ibid., Q. 1577.
29. Ibid., Q. 2010-2011.
30. First and Second Reports from the Select Committee on Medical Registration and Medical Law Amendment, 1847-48 (210), Q. 138.
31. Ibid., Q. 305.
33. Ibid., p. 226. See also Lancet, 1847, 1, p. 127.
34. First and Second Reports from the Select Committee on Medical Registration and Medical Law Amendment, Q. 602.
35. Holloway, op.cit., p. 223.
38. First and Second Reports, Q. 1152.
39. Lancet, 1832-33, 2, p. 121.
40. Hanaard, 21, 1834, col. 234.
41. Ibid., 21, 1834, col. 235-6.
42. Both petitions appear to have been drawn up in the mid-1830's, and were reprinted in the Lancet, 1840-41, 2, pp. 668-70.
44. Lancet, 1847, 1, p. 599.
45. Hanaard, 150, 1858, col.1409.
46. Ibid., 150, 1858, col. 1419.
47. Thoughts on the real and imaginary grievances of the medical profession, Lancet, 1841-42, 2, pp. 510-514; 606-614; 742-747; 776-783.
49. Ibid., 1841-42, 2, p. 606.
50. Ibid., 1841-42, 2, p. 606.
51. Ibid., 1841-42, 2, p. 510.
52. Ibid., 1841-42, 2, p. 606.
57. *Hansard*, 150, 1858, col. 1409.
59. As Charles Newman has noted, the 1858 Act seems to have been generally interpreted as giving to all registered practitioners the right to practise all branches of medicine and surgery; indeed, it was precisely because of this that there developed the scandal over "qualified" general practice on the strength of a single qualification. This situation was, of course, remedied by the Act of 1886, which required all practitioners registering after the Act to have a triple qualification in medicine, surgery and midwifery. See Charles Newman: *The Evolution of Medical Education in the Nineteenth Century*, O.U.P., London, 1957, pp. 227-8.
60. The general practitioners' major grievances were that they were not given direct representation on the General Medical Council, control of which was vested firmly in the hands of the medical corporations and the Universities, and that the Act did not impose penalties for unqualified practice, although it did impose penalties on unqualified practitioners who claimed to be qualified. See Newman, *op.cit.*, p. 190.
70. The Letter, dated 20th September 1774, is to be found in *The Wealth of Nations*, ed. by J.R. McCulloch, Edinburgh
and London, 1838, Note XX, pp. 582-585.
72. Hansard, 1843, col. 650.
74. Musgrove, op. cit., p. 106.
76. Ibid., 1847, I, p. 600.
77. Ibid., 1841-42, 2, p. 650.
78. Ibid., 1841-42, 2, p. 650.
79. Peterson, op. cit., p. 130.
80. Ibid., p. 134.
81. Ibid., p. 36.
83. See, for example, Hansard, 1844, 76, col. 1910, and Lancet, 1841-42, 2, p. 133, and ibid., 1858, 2, p. 120. See also the evidence of William Lawrence before the 1847 Select Committee, op. cit., note 8 above, Q. 1962.
84. Hansard, 76, 1844, col. 1905.
87. Peterson, op. cit., p. 31.
88. Medical Reform, Quarterly Review, 67, 1840-41, pp. 55-56.
89. Ibid., p. 57.
90. Ibid., p. 60.
91. Ibid., p. 56.
93. Ibid., 1847, I, p. 627.
95. These restrictions were set out in Clause 36 of the Act.
98. Hansard, 76, 1844, col. 1898.
100. These Census figures are taken from Musgrove, op. cit., p. 105. It should be noted, however, that Musgrove's figure of 15,901 practitioners in 1881 is a mistake; this should read 15,091.
101. The percentage growth of the exploited male population and the total population has been calculated from the figures in Perkin, op. cit., p. 128.
102. When Walter Rivington calculated doctor/patient ratios in his Carmichael Prize essay of 1879, he used slightly different figures for the increase in the total population from those given in Perkin, op. cit. However, these
differences were too small to make any significant difference between his conclusions and those set out in this essay. Thus Rivington calculated that the reduction in the provision of qualified medical care had been from 7.2 doctors per 10,000 population in England and Wales in 1861, to 6.4 per 10,000 in 1871. See Walter Rivington: The Medical Profession, Dublin, 1879, p. 2.

103. In 1861 there was one practitioner for every 1392 persons, and in 1911, one to every 1469.

106. Ibid., Q. 1165.
107. Ibid., Q. 1166.
108. Ibid., Q. 1168.

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Medicine, the Market and Professional Autonomy: Some Aspects of the Professionalization of Medicine

in W. Conza and J. Kocka (eds.)

*Bildungsbürgertum im 19 Jahrhundert*,
Klett-Cotta, Stuttgart, 1985, pp 388-416
Although the history of medical practice is a very long one, it has only been in the last hundred years or so that medical men in most Western societies have been able successfully to claim professional status for their work. In part, the emergence of medicine as a modern profession reflected the doctors’ own conscious efforts to raise the status of their occupation but, to a considerable extent, the rise of the medical profession was also dependent on changes within the wider structure of society — changes over which medical men themselves had little or no control — which provided the social structural conditions favourable to the emergence not only of medicine, but also of many other occupations, as modern professions. In order to understand this process of professionalization, therefore, it is necessary to examine the relationship between processes of change in the wider structure of society and changes within the structure of the profession itself. The object of this paper is to examine the interrelationship between two such processes which, it is held, were central to the development of medicine as a modern profession. The two processes to be examined are, firstly, the development of a relatively high level of professional autonomy on the part of medical men and, secondly, the growth of the market for medical care in the nineteenth century, a process which, it will be argued, had important implications for the development of the medical profession. Although the major focus of analysis throughout this paper will be on the development of the medical profession in England, many of the processes to be examined were by no means specific to the English situation and reference will, therefore, also be made at appropriate points to similar developments in other societies in both Western Europe and North America.

The fact that professional occupations are characterized by a high degree of autonomy has for a number of years been a central theme in much of the literature on the sociology of the professions; indeed, Eliot Freidson, in what is now widely regarded as the standard work on the sociology of the medical profession, has argued that it is precisely this professional autonomy or self-regulation — or what, in a different context, he calls “professional dominance” — which is the distin-
guishing characteristic of modern professional occupations. Thus the strategic
distinction between the professions and other occupations is held to lie in "legiti-
mate, organized autonomy — that a profession is distinct from other occupations in
that it has been given the right to control its own work." Any analysis of
the development of medicine as a modern profession must therefore include, as a major
part of that analysis, an examination of the development of medical men's author-
ity and control — over their work, their patients, and the organization of their
professional lives. What, then, were the processes through which the control of
medical practice came to be centralized within the profession itself in the course of
the nineteenth century?

It will be suggested in this paper that the development of medical authority and
control cannot be adequately understood without reference to the changing struc-
ture of the market for medical care in the eighteenth and nineteenth centuries, for
this changing market structure, it will be argued, was of major importance in prov-
ding the conditions under which medicine could develop as a relatively autono-
umous or self-regulating profession. Thus, it will be argued that the growth of the
market for medical care in the nineteenth century was, as Paul Starr has put it,
"one of the main currents deep beneath the changing structure of medical institu-
tions". Much of this paper will, therefore, be concerned with an analysis of the
changing structure of the market for medical care in the eighteenth and nineteenth
centuries, and with the ways in which different market structures either inhibited
or facilitated the development of a high level of professional autonomy.

On a general level, it is perhaps not unreasonable to suggest that one of the funda-
mental constraints operating on the producers of any product is the structure of
the market for that product. In view of this, it is perhaps surprising that so little
work has been done on the structure of the market for medical care in the eigh-
teenth and nineteenth centuries for, as Starr has noted, "the economic history of
medicine, especially before the 20th century, remains almost entirely to be writ-
ten". Unfortunately, information on the structure of the market for medical care
in the eighteenth century is relatively scarce, but nevertheless, a number of genera-
points can be made with a reasonable degree of certainty. The first of these is that,
throughout the eighteenth century, the provision of qualified medical care was
relatively unimportant as an economic activity, for medicine did not then consti-
tute the major industry which it has subsequently become in all industrialized so-

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2 Eliot Freidson: Profession of Medicine, New York, Dodd, Mead and Company, 1972,
especially chapters two and four. See also Freidson's Professional Dominance, Chicago,
3 Freidson, Profession of Medicine, p. 71.
4 Paul Starr: Medicine, Economy and Society in Nineteenth-century America, in P.
5 Ibid., p. 47.
cieties. Thus Philip Elliott has noted that the "pre-industrial professions handled areas of life involving potential social problems and conflicts but their specific contributions to the economy . . . were marginal" ⁶, whilst Freidson has drawn attention to the fact that prior to the nineteenth century, the services of qualified medical men were used by only a relatively small section of the population, for there was a variety of alternative sources of care which were not only freely available, but which were probably also more consistent with the indigenous belief systems of most ordinary people. Thus at the time when John Heysham was apprenticed to a country doctor in the second half of the eighteenth century, the regular practitioner had "much less of the confidence of the public than the itinerant quack. At all times he had to compete with the village blacksmith, the barber, and the herbalist, whose 'calling of simples' . . . impressed the vulgar mind with uncommon faith." ⁸ Freidson is almost certainly correct when he notes that "Official medicine . . . had only a loose, variable connection with the general cultural beliefs of the population . . . The bulk of everyday consultation of healers by the general population was not controlled by the organized medical occupation." ⁹ Indeed, most care of the sick was not even part of the market economy, for it took place within the context of familial or neighbourhood relationships which were outside the realm of market exchange.

Although it is difficult to make any very precise estimate of the size and structure of the market for qualified medical care in the eighteenth century, it is clear that the market — like the market for other specialized professional services ⁶ — was a relatively small one, and also that the demand for qualified health care tended to be relatively highly concentrated amongst the wealthier sections of the community. Thus Reader has pointed out that most of the population in the eighteenth century simply could not afford qualified medical care ⁶², whilst Rachel Franklin has similarly noted that most people in the predominantly rural society of eighteenth-century England were "not in the habit of calling in a doctor in times of illness. A few medical men settled in the local country and market towns and visited the richer inhabitants of the neighbourhood but the ordinary villager and agricultural worker could not afford to employ them. Old wives' tales, traditional herbal recipes, or charms, were the mainstay of the sick." ¹¹

⁸ Freidson, Profession of Medicine, p. 12.
⁹ In relation to the legal profession, for example, it has been noted that in the eighteenth century "the vast bulk of the population had no demand for legal services". See B. Abel-Smith and R. Stevens: Lawyers and the Courts, London, Heinemann, 1970, p. 14.
¹⁰ Reader, op. cit., p. 32.
It should not however be assumed that even those who could afford to pay for the services of qualified practitioners necessarily chose to use those services on a regular basis, for throughout the eighteenth century the traditions of domestic and folk medicine remained very strong whilst the use of unqualified practitioners was also very common, and there is some evidence from eighteenth century diaries to suggest that these alternative sources of care were frequently preferred to the services of qualified practitioners, even amongst relatively affluent and well educated groups. Thus it may well have been the case that qualified practitioners were by no means assured of a very stable or secure market for their services, even amongst those sections of the population which were able to afford qualified care. It should be emphasized, however, that in pre-industrial England — as in virtually all other pre-industrial societies — very many people were simply unable to afford the services of qualified practitioners, and for a great many of those in the poorer sections of society, domestic care and folk medicine, perhaps supplemented by the help of friends, neighbours or local lay healers, represented the only realistically available forms of health care. Thus it may be suggested that throughout the eighteenth century, the market for qualified medical care was limited both by the inability of large sections of the population to pay for qualified care, and also by the persistence of traditional attitudes towards health care which continued to emphasize the importance of sources of care other than that which was provided by qualified practitioners.

It is of some interest to note that the structure of the market for medical care outlined above was by no means unique to pre-industrial England; indeed, it would seem that a relatively low level of effective demand for qualified medical care may well be a characteristic of pre-industrial societies generally, including the pre-industrial societies of eighteenth-century Europe and North America. Thus, in describing the American situation, Starr has drawn attention to the relatively small size of the market for medical care in the eighteenth and early nineteenth centuries, and has argued that the "fundamental constraint on medicine in early American society was the relatively low level of demand for medical services, rather than any institutionalized restrictions on supply". Claudine Herzlich, in a recent paper

12 Thus the diary of Nicholas Blundell, who was the head of a landowning family in Lancashire, indicates that in times of illness, Blundell frequently chose to rely on his own domestic remedies, or alternatively to use the services of local part-time unqualified healers, who included his butler, the local innkeeper, and local women healers. The diary of James Woodford, who was the parson at Weston in Norfolk from 1773 to 1803, indicates a similar reliance on domestic medicine and lay care, with the services of the local qualified practitioner being used only "when the situation was desperate". See J. J. Bagley: Lancashire Diarists, London, Phillimore and Co., 1975, pp. 97—98, and N. C. Hultin: Medicine and Magic in the Eighteenth Century: the Diaries of James Woodforde, Journal of the History of Medicine and Allied Sciences, 1975, 30: 354-4.

13 Starr, op. cit., p. 51.
on medicine in France, has similarly drawn attention to the “absence of a real medical market” in the late eighteenth and early nineteenth centuries, whilst Jean-Pierre Goubert, in an analysis of medical practice in France around 1780, has described the pattern of demand for health care in terms which are equally applicable to the situation in eighteenth-century England. Goubert notes, for example, that the level of demand for qualified care was relatively low, and also that this demand was relatively highly concentrated amongst the higher status groups. Thus, in describing the pattern of medical care in French towns during this period, Goubert points out that “the visit of a practitioner was only within the financial reach of a minority” whilst in rural districts, even the fee of the country surgeon was too high for many sick people. Goubert adds that, since many people could not afford qualified health care, the level of demand for the services of the qualified practitioner did not vary as a direct function of the total population of the area within which the practitioner worked, but that it “depended mainly on the importance of the fraction of the population which called him to its bedside and which was able to pay him” whilst elsewhere he similarly notes that “the demand for health personnel emanates — in large part — from the social elite”.

Thus far it has been argued that the structure of the market for qualified medical care in the eighteenth century was characterized firstly by a relatively low level of demand for qualified care, and secondly, by the fact that this limited demand was relatively highly concentrated amongst the higher status groups. The third major characteristic of the market for medical care in England was that, throughout the eighteenth century, there was no real national market for medical care, but rather a series of loosely connected, more or less independent, local markets; again, this may well be a common feature of pre-industrial societies, in which the centralization of government and administration, and the integration of the society on a national level are, at least by modern standards, still relatively undeveloped. In England, the extent to which the organization and control of medical practice continued to reflect the traditional orientation towards local markets rather than towards a national market can perhaps be most clearly seen in the purely local, guild-like structure of the medical corporations. Thus throughout the eighteenth century there was no genuinely national organization which had either the inclination or the ability to control entry into the profession or, indeed, to regulate medical practice in any way. Instead, there was a multitude of purely local licensing

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16 Ibid., p. 217.
17 Ibid., p. 217.
18 Ibid., p. 214.
bodies, each of which was responsible only for the control of one particular branch of practice in its own locality.

Thus even the most prestigious of the licensing bodies in England, the Royal College of Physicians, was originally founded simply to control the practice of medicine in London and in an area of seven miles surrounding the capital, and although its powers were shortly afterwards extended to cover the whole of England, the College showed little interest in exercising these broader powers and, instead, continued to concern itself almost entirely with maintaining the exclusive status of a small group of elite practitioners in London. Thus, as the official historian of the College, Sir George Clark, has noted, throughout the eighteenth century the College “showed no interest whatever” in regulating medical practice outside London. The extent to which the College continued to concern itself almost exclusively with the London market can be gauged by the fact that it was not until 1783 that the College decided to add to its published Catalogue the names of those licensed to practise outside of London, that is to publish a list for the whole country. It is equally significant that in 1800, the College listed no less than 153 practitioners whom it had licensed to practise in London, whilst it listed only 26 physicians who were licensed to practise in the whole of the rest of the country. Indeed, it is not until the middle decades of the nineteenth century — at the very earliest — that the College can be regarded as having made any significant contribution to the provision of medical care outside of London.

Like the physicians, the surgeons and apothecaries continued to be organized, throughout the eighteenth century, in local guild-like organizations. Until 1745, of course, the surgeons were united with the barbers in the Company of Barber-Surgeons, which was one of the City of London Livery Companies and indeed, it was not until the Royal College of Surgeons was formed in 1800 that all connections between the surgeons and the City of London were formally severed. Even then it is significant that the full title of the College was the Royal College of Surgeons of London; the “London” was not changed to “England” until the mid-1840’s in a belated recognition of the fact that the College by this time, had become involved in supplying practitioners for a national market rather than a purely local one.

The third major group of practitioners — the apothecaries — were also organiz-
ed in what was a local society, for throughout the eighteenth century, the Society of Apothecaries merely had the power to regulate its members resident in London; it was not until the passing of the Apothecaries' Act in 1815 that the Society took on the responsibility for licensing practitioners on a national level.

Outside of London, medical practice was very partially regulated through a number of institutions, varying from the last remnants of ecclesiastical control through bishops' licences, to the local Barber-Surgeon's Companies which persisted into the eighteenth century in some of the more important urban areas. In Scotland, as in England, there were no national licensing bodies, but rather a number of universities and medical corporations, each of which exercised a limited jurisdiction within its own particular locality. Thus it may be argued that insofar as the medical profession was organized at all during this period, its organization reflected a traditional orientation towards local markets rather than towards a national market.

Perhaps the clearest single indication of this fact is that for most of the eighteenth century there was no national register of qualified practitioners; the first such register was The Medical Register for the Year 1779, which was published anonymously by Dr. Samuel Foart Simmons. Moreover, this register was a "purely private and unofficial venture", and doubtless it was also very incomplete. Nevertheless, Simmons' register was, as Sir George Clark has pointed out, "a landmark in the history of the profession. At long last in medical affairs the discovery of England was completed. It had become possible to know approximately how many members of each professional branch were in practice, and where. Vague speculation as to whether they were too few or too many in the country generally or in any particular region could now give way to calculations based on facts." The publication of a national register — even a very imperfect one — may be taken as an early indication of a growing awareness of the fact that the focus of the medical market was steadily shifting from the local to the national level. In this context, it is interesting to note that towards the end of the nineteenth century, C. B. Keatley advised the young practitioner who was about to embark on a medical career to make a systematic survey of prospective sites. He should, said Keatley, take into account the population of the town and, from the country directory, ascertain the number of gentry and clergy, and the number of medical men already in practice there. For the eighteenth century practitioner, such a rational and systematic survey of the potential market for his services was quite impossible, for

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28 Such local Barber-Surgeons' Companies persisted into the eighteenth century in Newcastle, Bristol, Norwich, Chester and York. See Cope, op. cit., p. 4.
the information required to gauge the level of demand for, or the supply of, medical services simply did not exist beyond the local level.

In summarizing the argument thus far, we may say that, throughout the eighteenth century, the major characteristics of the market — or, more precisely, the markets — for medical care were that the level of effective demand for qualified care was both relatively low and relatively highly concentrated in the higher social strata, and that these markets were local rather than national in character. What, then, were the implications of this market structure for the development of medicine as an occupation?

As we have already noted, Starr has suggested that the “fundamental constraint on medicine” in pre-industrial America was the relatively low level of demand for medical services, and he goes on to point out that “Whether it was because of popular preference for domestic care and disbelief in the value of professional medicine, or the difficulty of obtaining and affording treatment, or the ease with which competitors entered the field, many physicians found it extremely difficult to support themselves solely from medical practice . . . Starting out in practice frequently meant protracted underemployment and hardship.” ²⁷ Although Starr is writing specifically about the situation in pre-industrial America, his comments could, with equal accuracy, be applied to England in the eighteenth century, for in England, too, the low level of demand for health care meant that for many practitioners, medical practice on its own did not offer a stable or a permanent — or, indeed, a full-time — career. Thus a number of eighteenth century practitioners are known to have left the profession after failing to secure an adequate income from medical practice and, in some cases, practitioners appear to have entered and left the profession more than once in the course of their working lives ²⁸, whilst, in

²⁷ Starr, op. cit., p. 51.
²⁸ Amongst the more famous of those who left the medical profession after failing to secure an adequate income from medical practice were Georg Crabbe, Oliver Goldsmith and Tobias Smollett. Smollett, in fact, made two unsuccessful attempts to establish himself in practice, in 1744 and in 1750. The biographies of unsuccessful practitioners are as important as — perhaps more important than — those of successful practitioners in terms of what they tell us about the problems facing ordinary medical men. Unfortunately, the biographies of unsuccessful medical men are, of course, rarely written, and we know of the cases cited above only because, having failed in medical practice, they subsequently became famous in the world of literature. How many unsuccessful practitioners there were who never achieved fame in another field, like those above, we cannot know, but the number was probably considerable. On the medical careers of Crabbe, Goldsmith and Smollett, see The Life of George Crabbe by his Son, London, The Cresset Press, 1847; Lewis Mansfield Knapp: Tobias Smollett, Princeton, Princeton University Press, 1949; George M. Kahrl: Tobias Smollett, Chicago, University of Chicago Press, 1945; David Hannay: Life of Tobias George Smollett, London, Walter Scott, 1887; Ralph M. Wardle: Oliver Goldsmith, Lawrence, University of Kansas Press, and London, Constable, 1957. On the instability of
addition, very many more practitioners — probably a majority — were forced to supplement their modest incomes from medical practice with a second source of income.

The practice of having a second occupation in addition to medicine seems, in fact, to have been an extremely common one throughout the eighteenth century. Thus, during the period in which they tried, without success, to establish themselves in medical practice, both Tobias Smollett and Oliver Goldsmith accepted literary commissions in order to increase their total incomes. The practitioner to whom George Crabbe was apprenticed in 1768 similarly "had more occupations than one", for in addition to his practice as a country surgeon he also ran a farm. Undoubtedly the most common method of supplementing a modest medical income, however, was by adopting a very broad conception of the doctor's role which included not merely the compounding and dispensing of drugs, but also the keeping of a shop in which was sold a whole variety of goods, many of which appear to have been more closely related to the role of a retail trader than to that of a medical practitioner. The lower branches of the profession had, of course, strong historical links with certain aspects of the retail trade, and it is clear that those links remained strong throughout the eighteenth century. Thus in 1753, an advertisement announcing the sale of an apothecary's shop in Hampshire listed, along with the medical equipment, "some good Tobacco and a Tobacco Engine". Similarly, the stock of James Shergold, an apothecary practising at Salisbury in Wiltshire, included tea, chocolate, spirituous liquors and tobacco. Although such practices were particularly common amongst the lower branches of the profession, they were by no means unknown even amongst the elevated ranks of the physicians. Thus Claver Morris, a physician who was in practice at Wells in Somerset in the early eighteenth century, compounded cosmetics which he sold to his patients, and which included his "hair butter" and his face and eye lotion. In addition, he also supplied one client regularly with scented snuff.

It seems probable that these secondary sources of income slowly began to become less important towards the end of the eighteenth and the beginning of the nineteenth centuries. Thus Kett has observed that, during this period, a growing num-


19 Kahrl, op. cit., p. 12; Wardle, op. cit., pp. 73, 79.
20 The Life of George Crabbe, note 28 above, p. 17.
22 Ibid., p. 18.
ber of apothecaries were "leaving their shops and acquiring... a view of themselves as distinctly medical practitioners" 29, whilst elsewhere he has similarly noted that the surgeon-apothecary was beginning to develop "an idea of the requirements he would have to fulfill as a full-time medical practitioner." 30. Nevertheless, there is no doubt that throughout the eighteenth century it was an extremely common practice for surgeons and apothecaries to supplement their medical incomes by keeping a shop; indeed, the combination of medical practice and retail trade persisted until well into the nineteenth century, for as late as 1840 we find a correspondent of the Lancet arguing that surgeons should be compelled "to abandon the sale of patent pills, pastilles, perfumery, soap, etc." 31, a view which derived from the fact that, by this time, involvement in retail trade was increasingly coming to be seen as something which was incompatible with claims to professional status.

From what has been said, it is clear that throughout the eighteenth century medical practice on its own frequently provided only a very unstable and insecure method of earning a living. This fact is of some importance, for a major implication of the weak market situation of many medical practitioners was that, for as long as practitioners were unable to support themselves from medical practice alone, and for as long, therefore, as they had to have a second source of income, medicine was severely limited not only in terms of its development as a profession but, at a much more basic level, it was limited in terms of its development simply as a full-time specialized occupation. During the nineteenth century, of course, medicine did emerge as a highly specialized, full-time occupation as medical men lost not only their shopkeeping functions and their other secondary occupations, but as they also increasingly lost those functions which were ancillary to medical practice, such as the dispensing of drugs, as new specialized occupational groups arose and took over these functions. However, this process of occupational specialization, which may be regarded as the most basic pre-requisite for the emergence of modern professional occupations, could only develop within the context of a large and expanding market for health care which made it possible for medical men to support themselves and their families from the proceeds of medical practice alone, without the necessity to supplement their medical incomes by engaging in other, non-medical activities. Thus it may be argued that, for as long as the level of demand for qualified care was relatively low — as was the case throughout the eighteenth century — medicine was severely restricted in terms of its development into the relatively secure, specialized and full-time occupation which it was later to become.

It is important to remind ourselves, therefore, that in the eighteenth century, medicine not only had few of the characteristics of a modern profession but, even more basically, it was frequently only a part-time occupation. Moreover, this was

30 Ibid., p. 23.
by no means a peculiar characteristic of medicine in England, for a similar situation existed in other societies in the eighteenth and early nineteenth centuries. Thus Riznik has pointed out that in New England in the early nineteenth century, "most physicians were involved in a self sufficient economy which was generally unable to support professional men — lawyers, ministers, and doctors — at anything more than a low standard of living" 27, with the result that "perhaps the majority of New England physicians . . . made up income deficiencies by farming and supplying their own needs" 28. It seems probable that a not dissimilar situation existed in much of France in the eighteenth and early nineteenth centuries. Thus Claudine Herzlich has recently argued that because the market for medical care in France was a relatively small one during this period, many medical men had only a very small clientele, and the fees that they were able to charge "were often very low and insufficient for earning a living" 29. That this was certainly the case for at least some practitioners is confirmed by the recently discovered account book and journal of Thomas Hérier, which provide an unusually detailed glimpse into the practice and finances of a French country surgeon at the end of the eighteenth century. Lemay has calculated from Hérier's account book that during the whole of his thirty-two year career as a country surgeon, Hérier earned, on average, 263 francs a year, and she has commented that "no matter how devoted to his profession he was, Hérier could not support a family on these earnings" 30. Indeed, it is significant that when, after seventeen years in practice, Hérier went to register the death of his tenth and last child, his occupation was listed as "cultivateur" or farmer, a fact which, as Lemay notes, "shows the importance of what appeared to be his chief livelihood in the eyes of the parish priest" 31.

In the Netherlands in the eighteenth century, medical men similarly supplemented their medical incomes by engaging in a wide variety of second occupations, including those of barber, fisherman, innkeeper and bailiff, whilst other practitioners were employed in the law courts and in the beer trade. A particularly common combination of occupations in the Netherlands appears to have been that of surgeon, schoolmaster and secretary in local government 32. Thus not only in England,

38 Ibid., p. 7.
41 Ibid., p. 229.
42 Dirk Jan Baptist Ringoir: Plattelandschirurgijn in De 17e en 18e Eeuw, Bunnik, Uitgeverij Lebo, 1977, especially pp. 86—92. I am grateful to Henk Heijmen of the Socio-logisch Instituut, Universiteit van Amsterdam, for bringing this reference to my notice.
but probably in most societies in the eighteenth century, the relatively low level of demand for health care may be seen as a fundamental constraint on the development of medicine as a full-time, specialized occupation.

Thus far it has been suggested that the structure of the market for medical care in the eighteenth century was such that many medical men found it difficult to make a reasonable living from medical practice on its own. It would, however, be quite wrong to suggest that all practitioners faced similar difficulties in this respect. Thus we have already noted that there was a marked tendency for the demand for medical care to be concentrated in the higher social strata, and those practitioners who were fortunate enough to find favour amongst the aristocracy and gentry themselves enjoyed relatively high status and incomes through their association with a high status clientele. However, whilst this group of practitioners was able to enjoy the lifestyle appropriate to eighteenth century gentlemen, their involvement in the network of face-to-face relationships which made up the patronage system placed severe constraints on the development of professional autonomy. Thus, as a number of writers have noted, the patronage relationship was typically associated not with a structure of colleague control, but with a structure of client control, for under the patronage system it was the aristocratic and wealthy client who was the dominant figure in the doctor-patient relationship. Thus, as Holloway has pointed out, by virtue of the wider social bases of his power, the client was in a position to define both his own needs, and the manner in which those needs were to be met. As a consequence, “the patient, not the doctor, determined the conditions on which service was rendered”, whilst the doctor, “faced by powerful, wealthy, critical, demanding, and ill-informed patients was forced into the role of lackey and mere comforter”.

Holloway’s analysis of the patronage system has been considerably developed and elaborated by Jewson, who draws attention to the fact that medical men were dependent upon the favours of a small group of upper class patients who had the ability to make or break the career of any individual practitioner. Aristocratic patients, he points out, “were in a position to choose for themselves the most satisfactory or amusing practitioners from among the host of medical men who clamoured for their favours. It was the patient who judged the competence of the physician and the suitability of the therapy. The wealthy and influential threw their support behind whichever practitioner pleased them and withdrew it from those in whom they were disappointed. Thus it was the client who held ultimate power in the consultative relationship.” The patronage relationship was not, of course, peculiar to England and, indeed, Claudia Huerkamp has pointed to the existence of a similar relationship between medical men and their upper class patients in

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early nineteenth century Germany. Thus she notes that, "Zu diesen Patienten standen die Ärzte häufig in einem patronageartigen Abhängigkeitsverhältnis, waren also keineswegs der dominierende Part in einem Experten-Laie-Verhältnis, wie es für den modernen Arztberuf charakteristisch ist." The picture which emerges, in relation to both England and Germany, is not that of medicine as a highly autonomous profession, but rather that of an occupational group whose members were highly dependent on their lay patrons.

In a detailed analysis of the patronage system in England, Jewson has argued that this dependence of medical men on their lay patrons had important implications for the development—or, more precisely, for the relative lack of development—of medical knowledge in the eighteenth century. Thus he has suggested that, in a situation in which the client held ultimate power in the consultative relationship, physicians "had no choice but to tailor their theories and remedies to meet the expectations and requirements of their genteel clients." More specifically, he suggests that the distinctive characteristics of eighteenth-century medical knowledge—in its orientation towards symptoms rather than towards etiology, its monistic pathology, and the lack of any sharp distinction between afflictions of the body and the mind—may be related to the constraints placed upon practitioners in a situation in which the careers of medical men were under lay control, and in which practitioners were forced to compete with each other for the favours of a small group of wealthy and influential patients. Thus, in relation to the first of these characteristics—the orientation towards symptoms rather than towards etiology—he suggests that one manifestation of the patient's power under the patronage system was his ability to dictate the very definition of illness itself. "In particular the patient's understandable desire to be cured of his symptoms, rather than diagnosed of his disease, had an indelible impact on contemporary theories of nosology and pathology. Medical knowledge revolved around the problems of the prognosis and therapy of symptoms, rather than the diagnosis and analysis of diseases. Symptoms were not regarded as the secondary signs of internal pathological events, but rather as the disease itself. The attention paid by the medical profession to psychosomatic conditions such as hypochondriasis illustrates the point. When the wealthy and powerful chose to identify emotional stress with disease, practitioners accepted their definition of the situation and acted as if such maladies were real pathological entities. The symptom based nosology of the eighteenth century was thus a reflection of a patient dominated medical system." More generally, it may be suggested that the development of professional autonomy was severely restricted under the patronage system, for both the problems requiring solution, and the terms

44 Jewson, op. cit., p. 376.
in which an acceptable solution was defined, were determined by criteria established not by the profession, but by the patient. As we shall see, it was only in the nineteenth century that doctors finally achieved a position of dominance within the consultative relationship, and it was only then that the emphasis in medical research was able to move away from those problems which were of prime concern to the patient — that is, problems of therapy — towards the more basic scientific problems involved in the diagnosis and analysis of disease. The relatively high level of intellectual detachment of the nineteenth century medical scientist was thus, at least in part, a function of his growing social detachment from the patient.

One of the points which emerges very clearly from the work of Jewson, and from the work of other authors, is that the patronage system typically gave rise to a network of highly particularistic relationships between medical practitioners and their upper class patients. Thus wealthy and influential clients were in a position to demand personal attention and the practitioner — if he wished to make a success of his career — was constrained to orientate his behaviour towards the particular requirements of each individual patient. A similar point was made long ago by Carr-Saunders and Wilson in their classic study of the professions, in which they noted that the ties which bound the practitioner to his patron or patrons were those of loyalty and personal subservience, and they went on to note that this kind of relationship severely limits the development of professional consciousness and professional autonomy. Thus practitioners "who are in that condition of personal subservience do not easily associate with their fellows. Association might seem to indicate a striving towards an independence that would be incompatible with the relation of client to patron" 48.

A broadly similar point has also recently been made by Johnson, who has drawn attention to the fact that patronage is associated with a fragmented, locally oriented occupational group, whilst the individual practitioner defers to and identifies with his patron or patrons, rather than with his professional colleagues. Under these conditions, he notes, the sense of occupational community remains relatively undeveloped, whilst the authority of the patron reduces the possibility of developing professionally imposed forms of social control such as those involved in codes of professional ethics 49.

Johnson's contribution is an important one, not least because he points out the way in which an orientation towards local markets tends to fragment an occupational group by cutting practitioners off from their colleagues practising in other localities. Thus the patronage system has the effect of integrating practitioners into a network of relationships with clients at the local level whilst, at the same time, it inhibits the development of a network of relationships with colleagues at the national level, and it may be suggested that this fragmentation of the profession into a

48 Carr-Saunders and Wilson, op. cit., note 1 above, p. 300.
large number of small, relatively isolated groups of practitioners was one of the
processes which inhibited the growth of a common professional consciousness, or
any real sense of professional "community" in the eighteenth century. Quite clearly,
such a fragmented occupational group is unlikely to be able to develop its own
internally imposed controls on the behaviour of its members and, indeed, under
such conditions, the members of an occupational group are much more likely to
orientate their behaviour towards the expectations of their clients rather than to
wards the expectations of their colleagues. Thus as Freidson has pointed out, the
more the everyday work setting of a practitioner integrates him into a network of
relationships with professional colleagues, and the more the career structure of the
individual practitioner is determined by the evaluation of his colleagues, the more
the practitioner is constrained to orientate his behaviour towards the expectations
of his peers. In contrast, the practitioner whose work situation isolates him from his
colleagues is much less subject to any form of intra-professional control. However,
as Freidson notes, to the extent that a practitioner becomes less dependent on his
professional colleagues, he also becomes more dependent on his clients, for it is
they, rather than his colleagues, who are able to determine the practitioner's oc-
occupational success or failure.

As we have hinted above, there was, throughout the eighteenth century, nothing
resembling a "professional community" of medical men in any real sense, not even,
except in very rare cases, at the local level. Thus on the national level, there was
no regular medical press on a secure footing until the Lancet began publication in
1823, whilst a code of ethics governing professional behaviour was not highly ela-
borated — and certainly not rigidly enforced — until very much later. Even on
the local level there were few medical societies whilst the fact that practitioners
were involved in a highly competitive market in which there was a limited demand
for their services meant that relationships between medical men, far from being
cooperative, were often characterized by intense rivalry and mutual hostility.

As Porter has commented, the structure of professional occupations in the eight-
teenth century was such that it "did not tend to breed binding corporate profession-

69 E. Freidson; Client Control and Medical Practice, American Journal of Sociology,
1960, 65: 374—382. See also the same author's Profession of Medicine, especially chapter 5.
70 For an analysis of the development of medical ethics in England, see I. Waddington:
The Development of Medical Ethics — A Sociological Analysis, Medical History, 1975, 19:
36—51.
71 Amongst the earliest provincial medical societies in England were those which were
established in Warrington (1770), Colchester (1774), Huntingdon (1793), Plymouth (1794)
and Leicester (1800). For details of one such society, see Arthur Rook: General Practice,
1793—1803: The Transactions of a Huntingdonshire Medical Society, Medical History,
1960, 4: 236—252.
72 Jewson, op. cit., p. 382. See also Clark, op. cit., vol. II, pp. 543—546.
alism... Upward mobility was individual rather than collective. It was no-holds-barred in the clamour for advancement” 44.

It is clear that in such a situation, it was impossible for the profession to develop centralized, universalistic standards of either clinical or ethical behaviour which were independent of the particularistic customs and traditions of the local community; that this was so is clearly indicated by what, to the modern observer, appears to be the very “low” standard of professional behaviour characteristic of many eighteenth century practitioners. Thus intensely competitive relationships which frequently gave rise to public disputes, patented inventions, and the many forms of conspicuous self-advertisement which were characteristic of medical life in the eighteenth century would all, today, be regarded as highly irregular and unprofessional forms of behaviour. It would, however, be quite wrong to judge these forms of behaviour by today’s standards, for they simply indicate that the eighteenth century practitioner perceived — quite accurately — that in terms of his own career, it was more important to please his clients than to please his colleagues. Moreover, such forms of “unprofessional” behaviour could only be eliminated as this situation was reversed, that is to say, as medical career structures came increasingly under the control of the profession itself. This process, however, had to wait upon the expansion of the market for medical care, and the development of professional control of this enlarged market. It is to these issues that we must now turn.

In England, the expansion of demand for qualified health care in the nineteenth century appears to have been closely associated with the development of an increasingly complex, urban industrial society. As the College of Physicians itself noted, “The enlarged and improved state of society... has... much extended the demand for medical advice. Families which in a former condition of the Kingdom were either necessitated or content to apply for the relief of their indispositions to domestic medicine have recourse in these days of refinement and opulence to practitioners of Physic.” 45 In particular, it was the growth of a sizeable middle class which provided the basis for the rapid development of the medical profession in the nineteenth century, for as Holloway has noted, “the rise of the middle classes produced a prosperous, numerous and expanding clientele”, especially for those practitioners who were willing to provide their services at more moderate rates than those traditionally charged by the “consultant” physician and surgeon 46. The fact that it was possible for practitioners to offer their services at moderate rates was, at least in part, a function of the process of urbanization which, by concentrating the clientele of the medical practitioner within a comparatively small area, facilit-

45 Quoted in Holloway, op. cit., p. 318.
46 Ibid., p. 316.
ated a reduction in both travelling time and in the working expenses of the doctor's practice. In addition, certain innovations within the profession — notably the sliding scale of fees, which was increasingly widely adopted in the nineteenth century — also helped to make medical services more readily available to families living on relatively modest incomes, and thus had the effect of further widening the market for medical care.

Before we examine some of the implications of this changing market structure, it may be appropriate to examine briefly the processes which lay behind this growth of demand. Given the coincidence in the nineteenth century between the development of an increasingly scientific basis for medical practice and the expansion of demand for medical services, it is tempting to suggest that a higher level of demand was a reflection of the improved effectiveness of medical care. However, to assert the existence of such a simple relationship would be extremely misleading, for as many writers have pointed out, these improvements in medical science, whilst very real, did not immediately translate into therapeutic advances in medical practice; indeed, there is little evidence to suggest any dramatic improvements in the effectiveness of medical care prior to the early part of the twentieth century. Thus, as Starr has noted, "increased demand for medical services seems to have preceded significant improvement in the effectiveness of physicians." If, therefore, we wish to understand those processes which lay behind the growth in demand for medical care, we must look elsewhere.

In part, of course, the expansion of demand may simply have reflected the fact that in an increasingly prosperous society, an increasing number of people were able to afford specialized professional services such as those provided by medical practitioners. On the other hand, it is reasonable to suggest that the increased demand for health care may also have been associated with changing attitudes towards health and health care in the nineteenth century. Thus, in writing about Victorian England, Holloway has hypothesized that, at least amongst the middle classes, the widespread belief in progress and in the rational control of the world was extended to include the idea that man could control disease in much the same way that he was so busily controlling other natural forces. Similarly, he has suggested that the emphasis on individual achievement which was such a central feature of Victorian middle class belief systems necessarily placed a high premium on the maintenance of health, for good health came increasingly to be seen "both as a prerequisite for success and as a necessary condition for the enjoyment and exploitation of success." 


Starr, op. cit., p. 51.
Holloway, op. cit., p. 20.
On a more general level, it may be suggested that, both in England and in other Western societies, the growth in demand for qualified health care was also associated with the increasing emancipation from magic and from other forms of traditional thought, which was an aspect of the many-faceted process of rationalization, a process to which Max Weber, in particular, drew attention. As Weber pointed out, one aspect of this process of rationalization was the development of the "rational, systematic, and specialized pursuit of science", a process which, he notes, was distinctive to the West, at least in the degree to which rational science came to occupy the dominant place in our culture. In this sense — that is, in terms of the growing cultural dominance of science — the increasingly close association between medicine and science may well have been of considerable importance for, as Larson has put it, science during this period was coming to be seen as "the cardinal system of cognitive validation and legitimation". In other words, although the increasingly scientific basis of medical practice did not lead to any immediate and dramatic improvement in therapeutic effectiveness, nevertheless the cultural status of science almost certainly lent prestige and authority to the medical profession, and may well have been a significant process in increasing demand for the services of qualified medical practitioners.

It is perhaps worth noting that in one respect — that is, in terms of the role of the state — there was an important difference between the growth of the medical market in England and in some other Western societies. In England, the growth of this market appears to have been largely a "spontaneous" development which was associated with broader processes of social change, for, apart from the minimal provisions made under the Poor Law regulations, the state played virtually no part in directly regulating the market for medical services. In some other Western societies, however, the state intervened much more directly in the market for medical care, most notably by the development of state-sponsored health insurance schemes, which had the effect of bringing health care within the reach of groups who otherwise would almost certainly have been excluded from the medical market. This appears to have been what happened in Germany, for example, where, from a relatively early date, the medical profession was drawn into a network of state-bureaucratic relationships to a much greater extent than was the case in nineteenth century England. These variations in terms of the degree and the kind of state activity are, of course, important if one wishes to emphasize the distinctive charac-

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⁰¹ Ibid, pp. 15—16.


⁰³ This point is clearly brought out in the paper by Huerkamp, note 45 above.
teristics of the development of the medical profession in, say, England or Germany. On a more general level, however, these variations may be seen as specific differences in the precise mechanisms or processes which underlay a more general process — the growth of the market for medical care — which may be regarded as a common characteristic of most Western societies in the nineteenth century.

The processes which lay behind the expansion of demand for health care in the nineteenth century were, of course, extremely complex and, at the moment, by no means fully understood. However, although we may not yet fully understand these complex processes, it is clear that the emergence of a large and growing market for health care on a national level had important implications for the development of the medical profession, and it is to these that we must now turn.

In the first place, the growth of demand — in purely quantitative terms — meant that in the course of the nineteenth century, medicine came to offer an increasingly stable and lucrative long term career, a fact which was probably important both in terms of attracting recruits of a higher social status, and in terms of building up a sense of commitment to the profession on the part of those who had chosen a medical career. As we shall see later, in the second half of the century — especially after the profession had secured a significant degree of market control by restricting the supply of practitioners on a national level — the increasingly secure market situation of medical men was reflected in a significant increase in medical incomes.

It was not, however, simply the growth of the market in purely quantitative terms which was important; equally important was the fact that as the market grew, it altered not only the total amount of demand, but also the pattern of demand, by bringing into the medical market many clients whose socio-economic status was relatively modest. One consequence of this development was that patronage became an increasingly atypical form of the doctor-patient relationship, as the demand for medical care ceased to be concentrated, at least to the extent that it had formerly been, in the higher status groups. Thus, by the mid-nineteenth century, the doctor-patient relationship was typically no longer one in which the doctor faced a wealthy and powerful patron, but one in which the status of the patient was comparable to or lower than that of the doctor. Moreover, the fact that the doctor increasingly earned his living not by treating a small number of patients for relatively high fees, but by treating much larger numbers of patients for relatively modest fees, inevitably served to reduce the doctor's dependence on any particular patient. Under the patronage system, to displease an influential patient could, as Jewson has noted, have disastrous consequences for a practitioner's career; to displease a ledger-clerk, who was just one of many hundreds of patients, would hardly be likely to have the same sort of consequences. The relative statuses of doctor and patient in the wider society are always important elements in structuring the doctor-patient relationship, and there can be little doubt that the change in their relative statuses in the nineteenth century was an important part of the
process whereby the balance of power shifted increasingly away from the patient and towards the doctor.

The most dramatic illustration of the consequence of a change in the relative statuses of doctor and patient is undoubtedly to be seen in the context of the development of charitable hospitals for the poor in the late eighteenth and nineteenth centuries. Hospitals of this kind were developed, of course, in many Western societies and wherever such hospitals developed — in Britain, in France, in Vienna and in the U.S.A. — the fact that relatively high status practitioners were treating low status patients resulted in a dramatic reversal of the balance of power within the doctor-patient relationship. Thus doctors were — perhaps for the first time — able to ignore the wishes of individual patients, and to treat them according to criteria established not by the patient, but by the profession. The power structure within the mid-nineteenth century hospital, and the inability of the patient to control what happened to his body, is perhaps most poignantly captured by Entralgo who, in describing the situation in Vienna, has said that the patient had a “resigned and submissive attitude”; “he handed himself over with a wordless ‘Here is my body, do what you like with it’.” Both in Europe and in the United States, hospital positions became highly prized within the profession, partly because they gave access to a large amount of “clinical material” — as patients came to be called — in the form of a dependent and highly vulnerable hospital population.


35 Entralgo, op. cit., p. 117.

36 The reference to patients as “clinical material” is taken from Charles Bell Keatley’s The Student’s and Junior Practitioner’s Guide to the Medical Profession, London, 1885, which is cited in Peterson, op. cit., note 26 above, p. 174. Keatley praised the resources of a teaching hospital in the following terms: “The clinical material is simply overflowing, especially in the surgical and gynaecological departments, and there is any amount of opportunity for men to work clinically at dresserships and clerkships, if they will only come and finger the material for themselves. It is a perfect paradise for every kind of tumour known, and the accidents are numerous.” The whole tone of Keatley’s comments provides a clear illustration of the extent to which medicine had become — as Jewson has put it — “object orientated” rather than “person orientated”.

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was, of course, no accident that the hospital emerged as the centre of medical research and teaching in the nineteenth century. Nor was it an accident that it was within the hospital that one first sees the shift from what Jewson has called a “person orientated” to an “object orientated” medical cosmology; the patient was becoming increasingly depersonalized.

Of course, it is not suggested that the balance of power between doctor and patient was reversed in quite such a sudden and dramatic way in the situation of private practice; nevertheless a similar process, associated with a change in the status of patients, was occurring, albeit less dramatically, in private practice throughout the nineteenth century. As Haug has noted, the medical practitioner’s “degree of authority over clients depends in part on client characteristics rather than occupational characteristics alone” and it is important to bear in mind that the rise of medical dominance in the nineteenth century was a process which relied as much on a lowering of the status of the typical patient as on the raising of the status of the typical practitioner.

As we have already noted, it was in the hospitals that medical dominance emerged in its most highly developed form. This point is of some significance, for one aspect of the development of a national market for medical care was that, in relation to the supply of medical men, the process of producing medical practitioners moved increasingly away from the local level, and became centralized in a limited number of hospital medical schools, many of which enjoyed not merely a local, but also a national — and, in some cases, international — reputation. In order to understand the significance of this process of centralization, it is necessary to bear in mind that, throughout the eighteenth century, the great majority of practitioners had been produced through the apprenticeship system, which had a number of important consequences. In the first place, a highly decentralized, locally based system of education of this kind not only made it impossible to control entry to the profession on a national level but, equally importantly, it also made it quite impossible to enforce any standardized system of education. Thus training through the apprenticeship system was likely to be both haphazard and unsystematic, for since the apprentice was bound in a personal relationship to his master, the quality of the training which the apprentice received depended largely on the character and the abilities of the master to whom he was attached. Thus the country surgeon to whom George Crabbe was apprenticed in 1768 ran a farm in addition to his medical practice, with the result that Crabbe “was often employed in the drudgery of the farm...and was made the bedfellow and companion of the ploughboy.” It

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47 N. D. Jewson: The Disappearance of the Sick Man from Medical Cosmology, 1770—1870, Sociology, 1976, 10: 225—244.
49 The Life of George Crabbe, note 28 above, p. 17.
is not suggested, of course, that an apprentice could not learn a great deal of medicine if he was fortunate enough to be attached to an able and conscientious master; what is suggested is that the sort of education which an apprentice received almost certainly varied considerably from place to place, and from master to master. Thus not only the clinical education which an apprentice received, but also his socialization into what may be called the “job ways” of the profession, including acceptable standards of professional behaviour, was likely to reflect the particular demands of the local community within which his master’s practice was located. The particularistic relationship between doctor and patient in the eighteenth century was thus paralleled, in the sphere of medical education, by an equally particularistic relationship between teacher and pupil.

This situation began to change in the nineteenth century as the apprenticeship system steadily lost ground with the development of an increasingly centralized system of medical education, at first in the hospital medical schools, and later in the universities. Thus, in the first half of the nineteenth century, the terms of apprenticeship agreements were interpreted very loosely in order to allow apprentices to spend an increasing amount of time in the hospital and, although apprenticeship was never formally abolished, it continued to decline as a means of medical education throughout the second half of the nineteenth century. In place of a particularistic relationship with his master, the medical student in the nineteenth century came increasingly to receive his education within a formal institutional context which encouraged shared experiences with other students and, by so doing, facilitated the development of a shared professional identity and a sense of professional community. Thus, as medical students came from all over the country to these emerging national and regional centres of medical education, and as large numbers of students passed through the hands of a relatively small number of teachers, so the experience of medical education became a relatively standardized one in which all students were subjected to broadly similar influences. Moreover, the dominant values in these institutions, relatively well insulated as they were from the world of lay values and lay culture, were the values of the senior members of the profession. It thus became increasingly possible for this elite group of medical school teachers to define and to some extent to impose on all students their own definition of what constituted minimally acceptable standards of both clinical and ethical behaviour. Medical students were thus subject to an intensive socialization process which both fostered a sense of professional community and asserted the primacy of professional rather than lay values. In gaining control over the education and professional socialization of the next generation of practitioners, the elite group of medical school teachers was thus able to exert a considerable influence on the future development of the profession.

Thus far it has been argued that the expansion of demand for medical care, together with the steady shift in the focus of the market from the local to the national level, had a number of important implications for the development of the me-
medical profession. It is important to bear in mind, of course, that many aspects of this changing market structure derived from processes occurring within the wider structure of society, and that medical men had little or no direct control over many of these processes. Nevertheless, it would be quite wrong to suggest that the professionalization of medicine can be understood without reference to the conscious efforts of medical men themselves to raise the status of their occupation. In this sense, then, it may be argued that not only the changes within the structure of the market for medical care, but also the way in which the profession responded to these changes, can be seen as important determinants of the course of development of the profession.

In this connection, it is important to note that a higher level of demand for health care could not, of itself, guarantee any real increase in the incomes or status of medical practitioners, for if this increased level of demand was matched by an equal increase in the supply of medical practitioners, the position of the profession would be likely to remain relatively unchanged. Thus if the profession were to benefit significantly from the higher level of demand for its services, it was crucial for the profession to regulate the supply of qualified practitioners on a national level.

There is clear evidence to suggest that many practitioners were aware of this problem, for a major thrust of medical politics in the first half of the nineteenth century was concerned with the perceived need to restrict entry into the profession, an issue which was discussed frequently and quite openly in the medical journals. In the early 1830's, for example, the Lancet drew attention to what it felt to be the inadequate level of medical incomes, and argued that this situation was largely due to the fact that "the colleges are tempted by their [barters to admit] a number of practitioners, that sufficient rewards cannot be afforded to them." The evils of excessive competition, arising from what was held to be an oversupply of qualified practitioners, were also pointed out by the author of an article which was published anonymously in the Quarterly Review in 1840. Thus the author --- believed to have been Sir Benjamin Brodie --- argued that "the supply of medical practitioners is in fact not only very much beyond the demand, but very much beyond what is necessary to ensure a just and useful degree of competition ... In this, as in all other pursuits, a certain degree of competition is required for the security of the public; but in the medical profession it is easy to conceive that the competition may be not only beyond what is really wanted, but so great as to be actually mischievous".

Such complaints about overcrowding within the profession recurred frequently in the 1830's and 1840's. In the absence of a reliable national register of medical men it is, of course, difficult to know to what extent these complaints accurately

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89 Lancet, 1831—1832, 2: 89.
90 Medical Reform, Quarterly Review, 1840—1841, 67: 64.
reflected the real situation, and it should be borne in mind, as Perkin has pointed out, that complaints of overcrowding are almost as old as the professions themselves. Whether or not the profession really was overcrowded, however, it is probably fair to say that the expansion in the number of practitioners qualifying in the 1820’s and 1830’s almost certainly meant that medical men did not benefit as much from the higher level of demand for their services as they would have done if the supply of practitioners had been more restricted and, by the 1840’s, there was a general consensus amongst medical men on the perceived need to restrict entry to the profession.

Support for the principle of restricting entry to the profession came, in particular, from the Lancet, which was the most widely read medical journal during this period. Thus, in the early 1840’s, the Lancet argued that “many of the evils under which the profession now labours, are owing to the teeming multitude of practitioners” which, it said, “necessarily involves an impoverished state of the profession... The means of restraining this superfluity of doctors, and rendering the number of the profession more proportionate to the population become, therefore, very important objects of medical legislation”. The Lancet then went on to review a number of schemes for restricting entry to the profession, including the imposition of a direct numerical limitation, a plan which was rejected as being “incompatible with the institutions of a free country, and extremely difficult to reduce to practice under any circumstances”. Eventually the Lancet argued that the best way to restrict entry was by “making the standard of qualification high, as well in medicine as in letters and science”. If this scheme were adopted, “the numbers of the profession would be effectually limited without any injurious exclusions; the character of the profession would be greatly elevated, and the public welfare would be promoted”.

These proposals for the restriction of entry to the profession provide a clear illustration of what Weber has referred to as a “monopolistic tendency”, not in the sense of the creation of a formal legal monopoly for qualified practitioners — though there were very many medical men who were in favour of this — but in the more general sense of the monopolization of economic opportunities, in this case by what Weber has called “limiting the supply of candidates for the benefices and honors of a given occupation”. Moreover, it is important to note that this strategy of restricting entry to the profession was eventually to achieve a very substantial measure of success. Indeed, it is of some interest to note that many of the Lancet’s ideas on this subject were echoed almost exactly by William Cowper when

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73 Lancet, 1842—1843, 1: 764.
he introduced into the House of Commons the bill which subsequently became the 1858 Medical Act, and which largely defined the legal framework of modern medical practice in Britain by establishing the General Medical Council, and by requiring the Council to maintain a register of qualified practitioners. Thus Cowper argued that “at present there were more young men entering the profession than could gain a livelihood by it”, that the standard of qualification for medicine was too low, and that his bill sought to establish an adequate minimum standard. “If the low standard were raised,” he argued, “benefit would be obtained by more skilful treatment, and to the profession by reducing the competition of those who undervid one another from the want of remunerative practice.”

Cowper’s bill, as we have noted, eventually became the 1858 Medical Act, and this Act has generally — and quite correctly — been seen as the major legislative landmark in the development of the medical profession in nineteenth-century Britain. Although it is not possible within the confines of this paper to examine all the consequences of the Act in detail, it is possible to indicate the way in which the establishment of a medical register under the centralized control of the General Medical Council led to a significant extension of medical control over the market for health care. Thus not only did the 1858 Act lead to a further centralization of the control of medical education, but, equally importantly, this degree of centralized control also made it possible effectively to restrict entry to the profession on a national level, as many practitioners had hoped it would. Thus, in the twenty years or so following the passage of the Act, the growth in the number of medical practitioners in England and Wales was quite minimal, and was far outstripped by the growth of the total population. In 1861, there were 14,415 medical practitioners in England and Wales. In the decade from 1861—1871, this number increased by just 269, or 1.8%, and in the period from 1871—1881, there was a further increase of 407, or 2.7%77. Thus, over the twenty year period from 1861—1881, the number of medical practitioners in England and Wales increased by under 5%, compared with a 24% increase in the employed male population, and an increase in the total population of no less than 29% over the same period78.

Inevitably there was therefore, in the two decades following the 1858 Act, a marked reduction in the provision of qualified medical care to the population. In 1861, for example, there was one medical practitioner for every 1392 persons, or 7.1 doctors per 10,000 population. By 1871, this had been reduced to one practitioner for every 1437 persons, or 6.4 doctors per 10,000 population, and by 1881 there had been a further reduction to one doctor for every 1721 persons, or 5.8

77 Hansard, 1858, 150: col. 1407, and 1858, 149: col. 650.
78 All calculations are based on the Census figures for 1861, 1871 and 1881.
79 The percentage growth of the employed male population and of the total population have been calculated from the figures in Perkin, op. cit., p. 128.
doctors per 10,000 population. It is true that in the period from 1881—1901 there was a considerably more rapid rise in the number of qualified practitioners, perhaps partly due to the fact that by the late 1870's and 1880's there was a clearly recognized shortage of doctors, but as late as 1911 there were still fewer qualified practitioners in relation to population than there had been fifty years previously.

What is particularly pertinent within the context of the present argument, however, is that a situation which was generally regarded as being one of a surplus of doctors prior to the 1858 Act had, within two decades of the passing of the Act, become one in which there was a serious shortage of qualified practitioners. In his Carmichael Prize essay of 1879, for example, Walter Rivington drew attention to "the decrease in the supply of medical men", and he pointed out that William Farr, who was at that time Superintendent of the Statistical Department in the Registrar General's Office, had also expressed his concern that qualified medical care was becoming steadily less available. Indeed, Farr held that the shortage of medical men had become so serious that there was "an imminent danger" that qualified medical care might become "quite inaccessible to vast numbers of people".

The shortage of qualified medical men was also an issue which concerned the 1882 Royal Commission which had been appointed "to Inquire into the Medical Acts", and some of the evidence which the Commission received made it quite clear that the Lancet had not been mistaken when, many years previously, it had argued that the most effective way to restrict entry to the profession was "by making the standard of qualification high". Thus Professor Humphry, the Professor of Anatomy at Cambridge University, noted that medical men had "decreased in number relatively" and he agreed that there was a "danger of the examination becoming too strict". He pointed to the "greatly increasing proportion of rejections" of candidates for a licence to practise medicine, for the proportion of rejected candidates had increased from 14 per cent in 1867 to 23 per cent in 1875. Asked directly whether he felt that "this increasing stringency of examinations has inter-

78 When Walter Rivington calculated doctor-patient ratios in his Carmichael Prize Essay of 1879, he used slightly different figures for the increase in the total population from those given in Perkin, op. cit. However, these differences were too small to make any significant difference between his calculations and those set out in this paper. Thus Rivington calculated that the reduction in the provision of qualified practitioners had been from 7.2 doctors per 10,000 population in England and Wales in 1861, to 6.4 doctors per 10,000 population in 1871. See Walter Rivington: The Medical Profession, Dublin, 1879, p. 2.

79 In 1861 there was one qualified practitioner for every 1392 persons, and in 1911, one to every 1469.

80 Rivington, op. cit., p. 2.

81 Report of the Royal Commission appointed to Inquire into the Medical Acts, 1882 (C-3259-1), Question 1671.

82 Ibid., Question 1165.

83 Ibid., Question 1166.
fered with the public interest by diminishing too much the supply of medical men”, Humphry replied, “I believe it is so to some extent. When the examinations were increased, after the recommendations of the General Medical Council... were adopted, there was a sudden diminution of members in the profession.” The link between the 1858 Medical Act and the subsequent shortage of qualified practitioners could not have been made more explicit. The Act had proved to be, as most practitioners had hoped it would, a most effective way of restricting entry to the profession.

There is some evidence to suggest that, perhaps not surprisingly, this restriction of entry to the profession was associated with a significant improvement in the earnings and status of medical practitioners. Thus St. Thomas’s Hospital, in the evidence which it submitted to a Government Committee in 1878, drew attention to the “steady and progressive decrease of the number of medical practitioners in the United Kingdom, proportionately to the population”, and it added that “It is certain that within the same period the remuneration of medical men occupied in civil practice has greatly increased... The social status and influence of civil medical practitioners has undoubtedly increased with their increased earnings.”

Systematic information on the incomes of medical practitioners during this period is rather difficult to obtain, and for this reason the report of the above Committee is of some importance. The Committee had been established because of government concern about the declining number of recruits to the Army Medical Department and, as part of its investigation, the Committee compared conditions of work and incomes in civilian and military practice; in order to estimate the average income in civilian medical practice, the Committee invited submissions from most of the medical schools and universities, whilst some individual practitioners also submitted evidence. Most estimates of incomes in civil practice showed a substantial amount of agreement, and all of them further agreed that medical incomes had risen in the previous two or three decades. In the evidence which it submitted to the Committee, St. Bartholomew’s Hospital estimated the average income of a country general practitioner as between £ 600—£ 1000 per year after ten years in practice, with the incomes of general practitioners in urban areas being somewhat higher. This estimate was broadly in line with that submitted by St. Thomas’s Hospital, which held that the majority of young men “of superior education” will be found “at the end of ten years from their entry into practice to be earning from £ 500 to £ 1500 a year, or more” The Westminster Hospital similarly held that “our men are very soon able to marry and earn incomes varying from £ 500 to

88 Ibid., Question 1168.
89 Report of the Committee appointed by the Secretary of State to enquire into the causes which tend to prevent sufficient eligible candidates from coming forward for the Army Medical Department, 1878 (C-2200), p. 28—29.
90 Ibid., p. 49.
£1000 a year," whilst Dr. Hewitt from University College, although declining to give specific figures, offered the opinion that a "well educated industrious student finds little difficulty in the present day in establishing himself in civil practice, and if his abilities are of an average character he is certain within a short time to obtain a tolerably good income." The general conclusion reached by the Committee was that "Taken one with another, a medical man obtains in civil life a net income of £300 a year within 5 years of commencing practice. After 10 years he is unlucky if he does not net £500 a year, and thence his income gradually rises to an average of £800 to £1000. Of course, in exceptional cases these rates of income are very far exceeded." Even if one allows for the fact that the desire of medical witnesses to encourage the government to raise military surgeon's salaries may have led them, perhaps unconsciously, to inflate their estimates of earnings in civilian practice, it is clear that the market situation of medical men in the late nineteenth century was a steadily improving one, and one which was able to offer what Dr. Hewitt called "a tolerably good income" for the practitioner of average ability, and very much more than this for the practitioner of outstanding ability.

In conclusion, it has been argued that the market situation of medical practitioners changed quite radically in the course of the nineteenth century and that, as a consequence, what had formerly been a relatively insecure and frequently a part-time occupation had, by the end of the century, developed into a relatively stable, secure and rewarding full-time career. Moreover, from the early part of the century, the structure of both medical practice and medical education had been changing in ways which facilitated the development of a strong sense of professional community and identity, and which increasingly enabled medical men to assert the primacy of professional values over those of the lay world. As a result of these developments, medical men came to enjoy not only a relatively secure and steadily improving market situation but, equally importantly, they also came to enjoy a steadily increasing degree of authority and control over their work, over their patients, and over their own careers. Medicine, in other words, was emerging as a modern profession.

Finally, it is important to emphasize the fact that, although this paper has focused primarily on the development of the medical profession in England, many of the processes analyzed in this paper were also to be found in many other societies. Thus, for example, the growth of the market for qualified medical care is a process which has generally tended to occur within the context of the development of more complex, urban industrial societies in many parts of the world. The cen-

87 Ibid., p. 49.
88 Ibid., p. 29.
89 Ibid., p. 22.

Vorbemerkung: Die vollständigen Titel abgekürzter Literatur finden sich in der Bibliographie.
rationalization of medical education and the establishment of an official register of qualified practitioners are similarly processes which have occurred as part of the development of the medical profession in many different societies. Thus whilst it is not suggested that all the details of this analysis can be applied, without modification, to other societies, it is hoped that the general framework outlined in this paper may serve as a useful starting point for more detailed comparative analysis of the development of medicine as a modern profession.
The Movement towards the Professionalisation of Medicine

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The movement towards the professionalisation of medicine

Ivan Waddington

The publication in 1840 of the first issue of The Provincial Medical and Surgical Journal—the forerunner of the British Medical Journal—was one of several developments that indicated a growing professional consciousness among medical practitioners in the mid-nineteenth century. These developments were all part of a broader process as a result of which medicine in the course of the nineteenth century came increasingly to develop those characteristics that we associate with modern professional occupations. The celebration of the 150th anniversary of the BMJ is perhaps a particularly appropriate time to glance back and examine some aspects of that process of professionalisation, a process in which the BMJ itself played a not unimportant part.

In recent years much of the sociological literature on the professions has focused on the fact that professional occupations are characterised by a high degree of autonomy or self-regulation; indeed Eliot Freidson in his influential Profession of Medicine: a Study of the Sociology of Applied Knowledge argued that it is precisely this autonomy that is the distinguishing characteristic of modern professions. Clearly, therefore, the development of professional autonomy must be seen as a central part of the process of professionalisation. Accordingly the following analysis of the professionalisation of medicine takes as its major focus the development of medical autonomy or—to put it slightly differently—the development of medical practitioners' authority and control over their work and over the organisation of their professional lives. Specifically, I examine the development of professional control in relation to protection against unqualified competitors; control over entry to the profession; medical ethics; and medical education. Central to all of these issues was, of course, the establishment of a controlling body for the profession.

Overcrowding and competition

One issue that was of considerable concern to doctors in the early nineteenth century was that relating to the supply of medical practitioners. The problem here was twofold. Firstly, from the 1820s onwards there were continual complaints from doctors that the profession was overcrowded. Though contemporary complaints about overcrowding should be treated with caution, there are grounds for thinking that in this case there may well have been some substance in these complaints. It is certainly true that in the 1820s and 1830s there was a very rapid increase in the number of people who qualified from the College of Surgeons and from the Society of Apothecaries, and it seems highly probable that, at least in the two or three decades from the 1830s, the profession was indeed overcrowded.

The second problem related to competition from unqualified practitioners. Here the conventional argument within the profession was that medical education was an investment and that unqualified practitioners were denied those who were qualified a legitimate return on that investment. Qualifiers of that process also pointed to the harm that unqualified practitioners allegedly did to patients, though, as Peterson has pointed out, at that time the scientific arguments in favour of limiting practice to the qualified were not very strong and most practitioners themselves "seemed to see the issue more in terms of protection from competition than in terms of the superior claims of medical science." These problems gave rise to widespread demands within the profession for the establishment of a system of registration and the stipulation of minimum training requirements. The culmination of what proved to be a lengthy campaign for registration was the Medical Act of 1858.

In terms of the development of medicine as a modern profession the primary importance of the 1858 Medical Act lay in the fact that in establishing the General Council of Medical Education and Registration—more commonly known simply as the General Medical Council—it also established the institutional basis of the modern structure of professional self-regulation for, as the membership of the council consisted primarily of doctors, the profession was in effect being given the task of regulating itself. Specifically the act required the council to regulate the profession on behalf of the state, to oversee medical education, and to maintain a register of qualified practitioners.

What then was the effect of the act on an "overcrowded medical profession besieged by an army of irregulars"? Although the act did not make unqualified practice illegal—in an age of laissez-faire the legislature was very suspicious of anything that smacked of monopoly—it did set up a clear legal boundary separating the qualified from the unqualified while imposing certain disabilities on the unqualified. In the long run the most important of these disabilities was un-
doubtedly the exclusion of unregistered practitioners from government service, for this exclusion was to assume greatly increased importance with the huge expansion of public sector health care in the late nineteenth and twentieth centuries. In addition to the disabilities that it imposed on unregistered practitioners the act also conferred what might be called a "competitive advantage" on those who were registered because, as Stacey has put it, registered practitioners became "the officially recognised healers."

In relation to the issue of overcrowding within the profession there are grounds for suggesting that the establishment of a system of registration under the centralised control of the General Medical Council did make it possible—for example, by raising the standard of qualification—more effectively to restrict entry to the profession. Some of the evidence presented in the 1882 Royal Commission that was appointed to inquire into the medical acts suggests that this is exactly what happened after the passage of the 1858 act. Recruitment to the profession certainly fell quite dramatically, with the result that by the late 1870s there was a publicly recognised shortage of practitioners. This was, for example, one of the issues that concerned the 1882 Royal Commission, while William Farr, at that time superintendent of the statistical department in the Registrar General's Office, held that the shortage of practitioners was such that there was "an imminent danger" that qualified medical care might become "quite inaccessible to vast numbers of people." The contrast with the situation before the act could hardly have been more striking.

Medical ethics

In addition to developing an appreciable degree of control over entry to the profession, medical practitioners also extended their control over many other aspects of medical work. The elaboration and the more effective enforcement of a code of medical ethics in the nineteenth century was an important part of this process. On the most general level the development of a modern code of medical ethics entailed a movement towards the establishment of a system of social control in which the professional activities of doctors came increasingly to be regulated by the actions and sentiments of their professional colleagues. That many nineteenth century practitioners came to be concerned with ethical problems in the practice of medicine is indicated by the many articles on the subject in medical journals and by the publication of several books, of which the most famous was Thomas Percival's Medical Ethics, published in 1803 and generally regarded as the work that marked the development of a specifically modern code of ethics.

As doctors today grapple with new ethical problems associated with patient care and medical technology—for example, problems associated with organ transplants or embryo research—it may come as a surprise to learn that nineteenth century works on medical ethics, including Percival's classic text, were not concerned primarily in regulating the behaviour of doctors towards their patients, but rather their main concern was to regulate the behaviour of doctors towards their fellow practitioners. On reflection, it is not difficult to understand why this was the case, given the specific conditions under which doctors at the time were working. The medical world in the first half of the nineteenth century was changing rapidly. The pre-industrial distinctions between physicians, surgeons, and apothecaries were rapidly losing whatever relevance they had once had, while the modern division of the profession into consultants and general practitioners was steadily emerging. Within this context of rapid social change the roles and relative status of different kinds of practitioners became confused and unclear, thus creating numerous opportunities for professional misunderstandings and conflicts. These interprofessional tensions were exacerbated in the first half of the century by the overcrowding within the profession, as this meant that relationships between practitioners serving similar or overlapping neighbourhoods were often highly competitive, and allegations of unprofessional conduct, particularly relating to the poaching of patients, were common.

Given this, it is not surprising that those who wrote about ethical matters should have seen their most urgent task to be the regulation of relationships among practitioners in order to reduce what was widely recognised as an excessive and potentially damaging level of interprofessional conflict and competition. Consequently most discussion of ethical issues in the nineteenth century focused around the regulation of what were felt to be particularly delicate areas of interprofessional relationships, where conflicts were particularly likely to occur; the more obvious of these included such things as attending a patient of another
practitioner, managing consultations between two or more practitioners, and regulating what were often delicate relationships between consultants and general practitioners. In the second half of the nineteenth century a code of medical ethics was further elaborated and—perhaps more importantly—more effectively enforced within the profession. The more effective enforcement of what were increasingly coming to be regarded as "proper" standards of professional conduct was a process that was considerably facilitated by the establishment of the General Medical Council because under the 1858 act the council was given formal power to discipline practitioners and, as a final resort, to remove from the Medical Register any practitioner who was judged by the council to have been guilty of "infamous conduct in any professional respect." After 1858, therefore, the adherence to certain basic principles in the conduct of medical practice was no longer something that depended on the voluntary acceptance of those principles by each individual practitioner, for increasingly minimum standards of professional behaviour were not only defined but also enforced by a central body that had legally defined powers to discipline those practitioners whose conduct, in its view, fell below those minimum standards.

Centralisation of medical education

In relation to the professionalisation process the importance of changes in the structure of medical education in the nineteenth century should be noted. Throughout the eighteenth century all but a tiny minority of practitioners received their training through the apprenticeship system. This was, of course, a highly decentralised system of training in which apprentice and master were bound in a personal relationship, and consequently the quality of training that an apprentice received would certainly have varied considerably from one master to another. In the nineteenth century this traditional apprenticeship system steadily lost ground with the development of an increasingly centralised system of medical education—firstly, in the hospital medical schools and later in the universities. With the growth of the hospital schools apprentices began to spend an increasing amount of time in the hospitals and, although apprenticeship was never formally abolished, it continued to decline throughout the second half of the nineteenth century. One consequence of this development was that in place of a personal relationship with their masters, medical students in the nineteenth century came increasingly to receive their professional education within a formal institutional context that encouraged shared experiences with other students and, by so doing, facilitated the development of a common professional identity and a sense of professional community. As students came from all parts of the country to these emerging regional and national centres of medical education and as large numbers of students passed through the hands of a relatively small number of teachers the process of medical education became a relatively standardised one in which all students were subjected to broadly similar influences. Moreover, the dominant values in these institutions, well insulated as they were from the world of lay culture and lay values, were the values of the senior members of the profession. It thus became increasingly possible for this senior group of medical school teachers to define and to impress on all students their own professionally generated conception of what constituted minimal acceptable standards of both clinical and ethical behaviour. As a result of these changes in the structure of medical education medical students underwent a new and more intensive process of professional socialisation that both fostered a sense of professional community and asserted the primacy of professional rather than lay values. Medicine, in other words, was well on the way to becoming a modern profession.

7 Percival T., Medical ethics. Harmond: S Russell, 1803.

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SECTION TWO
The Medical Profession in the Industrial Revolution

Gill and Macmillan, 1984
The Medical Profession in the Industrial Revolution
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IT may be useful, at the outset, to say a few words about the title of this book, in order to make clear to the reader what the book is about and, equally important, what it is not about.

Firstly, it should be made clear that the term 'industrial revolution' is not used in order to designate a particular period of time, but rather, it is used to refer to a social process or, perhaps more accurately, to refer to a number of interrelated social processes. Thus the title should not be taken as an indication that this book is concerned simply with the analysis of the medical profession in a clearly bounded period of time such as, for example, the period from 1780 to 1830 or 1840. Rather, the title of this book is meant to suggest that the central focus of the analysis is on the interrelationships between the development of the medical profession and a whole series of other processes — changes in the occupational structure and class structure, the development of a more prosperous society, increasing levels of centralisation of administration, and many other processes — all of which were associated both with the development of English society as an increasingly complex, modern, urban industrial society, and with the emergence of medicine as a modern profession. In a sense, therefore, a more precise title might have been something like 'The development of the medical profession and the development of England as a modern industrial society'. I trust, however, that the reader will understand my reasons for wishing to avoid such a cumbersome title.

Secondly, the reader, I am sure, will not have failed to notice the reference to England rather than to Britain in the
above paragraph. Although there are occasional references to Scotland in this book, it should be pointed out that the analysis contained in the following chapters is concerned specifically with the development of the medical profession in England, and that much of this analysis is not directly applicable to the situation in Scotland. The major reason for this is that, as is well known, the development of Scottish society was in some important respects different from the development of English society and these differences were reflected in, amongst other things, a different structure of both medical practice and medical education in Scotland in the eighteenth and early nineteenth centuries. Thus, to cite but two examples, the apothecaries never developed as a distinct occupational group in Scotland, as they did in England, whilst at least some of the Scottish universities also instituted a regular and systematic programme of medical education long before such a programme was available in the English universities. The development of medical practice in Scotland raises, therefore, some rather different issues which merit separate treatment and, if only for the sake of simplicity, it has been decided to confine this work primarily to an analysis of the situation in England.

The book itself is divided into three major parts. The first part focuses on the rapidly changing structure of the medical profession in the early part of the nineteenth century, and with some of the intraprofessional conflicts which were associated with these changes. The second part consists of an examination of the lengthy campaign for medical reform which was associated with some extremely bitter disputes within the profession and which eventually led to the passage of the 1858 Medical Act and to the establishment of the General Medical Council which still remains the central governing body within the profession today. It was, of course, in the nineteenth century, and particularly in the latter half of the century, that the medical profession began to emerge in something like the form in which we know it today, and the third and final part of the book examines some of the major processes which were associated with the emergence of medicine as a modern profession.
PART I

The Medical Profession and Medical Practice in the Early Nineteenth Century
1.

The Institutional Structure of the Medical Profession in Early Nineteenth Century England

'THE law recognises only three orders of the medical profession: physicians, surgeons and apothecaries.' Thus wrote John Willcock in 1830, and the tripartite division of medical practitioners described by Willcock has generally been seen by modern historians as a major key to understanding the structure of the medical profession in the early nineteenth century. This is not perhaps very surprising, for this tripartite classification did indeed correspond not only to the three legally recognised groups of medical men, but also to the separation between the three major medical corporations in England, and to the type of education held to be appropriate for each of the three grades of practitioners. Although it will be argued later that this classification of practitioners also gives us what is, in certain other respects, a very misleading picture of the everyday structure of medical practice during this period, it is nevertheless the case that, without some understanding of this tripartite institutional structure, it is impossible to develop an adequate analysis of some of the major developments within the medical profession in the first half of the nineteenth century. Accordingly, therefore, our first task is to provide a brief outline of this tripartite structure; in the next chapter we will examine in some detail the extent to which this formal institutional structure actually corresponded to the routine day-to-day practice of medicine in the early nineteenth century.

In eighteenth and early nineteenth century England, there were three quite separate medical corporations — the Royal College of Physicians, the Company of Surgeons (from 1800 the Royal College of Surgeons) and the Worshipful Society of Apothecaries — each of which had its own charter and its own
bye-laws, and each of which granted licences to practise in
the particular branch of medicine or surgery for which it was re-
ponsible. The oldest and unquestionably the most prestigious
of these corporations was the Royal College of Physicians,
whose charter dated from 1518. With certain modifications
and extensions, the powers of the college were confirmed
by an act of 1522, which stated that it was 'expedient and
necessary to provide that no person . . . be suffered to exer-
cise and practise physic but only those that be profound, sad
and discreet, groundedly learned, and deeply studied in
physic'. It was therefore enacted that no person except a
graduate of Oxford or Cambridge should be allowed to practise
physic unless examined and approved by the College. Those
who had been examined and approved were divided into three
groups: fellows, licentiates and extra-licentiates. Whilst the
former two groups were licensed to practise medicine in
London and in an area seven miles around the capital, the
extra-licentiates held a licence which entitled them to practise
only outside of London. Neither the licentiates nor the extra-
licentiates, however, were allowed to take part in the formul-
ation of College policy, nor were they allowed to vote in
College elections. All political offices and all decision-making
functions within the College were monopolised by the fellows,
almost all of whom were graduates of Oxford or Cambridge;
in the period from 1771 to 1833 only nineteen of the 149
practitioners admitted to the fellowship had not graduated at
one or the other of these universities.

Throughout the eighteenth and early nineteenth centuries,
the College remained a small and exclusive body; in 1800, the
total number of fellows, licentiates and extra-licentiates was
just 179, which probably represented about three per cent
of the qualified medical practitioners in England and Wales.
However, as Peterson has pointed out, 'Size . . . was no meas-
ure of their strength. Their ancient collegiate foundation,
their tradition of classical learning, the absence of trade or
craft functions in the physician's work — all these contributed
to the position of the Royal College of Physicians as the most
prestigious of the medical corporations.'

The image of the physician fostered by the College was
that of a gentleman, learned in the classics and educated
alongside the gentry at the English universities. Towards the end of the eighteenth century, Thomas Withers, physician to the York County Infirmary, wrote that "The character of a physician ought to be that of a gentleman, which cannot be maintained with dignity by a man of literature." Classical, literary and philosophical studies were held to be at the very heart of a physician's education, for as the Gentleman's Magazine pointed out in 1834, the distinguishing characteristics of the English academic physician were 'large attainments as a scholar, . . . sound religious principles as a Christian, . . . practical worth and virtue as a good member of society, and . . . polished manners as a well-bred gentleman'.

Charles Newman has bluntly but accurately commented that 'the ideal aimed at was a cultured and highly educated gentleman, with, quite secondarily, an adequate knowledge of medicine'.

It was in this context that the close relationship between the College and the universities of Oxford and Cambridge was of importance, for the real significance of these universities lay in the fact that they provided an education in classical languages and literature, and in morals and manners, which made the young physician fit to take his place in polite society; and, closely associated with this, in the fact that it was in these universities that the future leaders of the church and state were educated. Thus in 1834 William McMichael, physician to the king and a former registrar of the College, held that the high status enjoyed by physicians was primarily due to 'the circumstance of many physicians in this country being educated at the English Universities. There they have the same education as those who fill the highest stations in life; they are brought up with those persons, and afterwards become physicians. I think the distinguished post which they hold elevates the whole profession; that all physicians partake of the dignity which their education and their good conduct give.' A similar point was made by Henry Holland, a fellow of the College, who pointed to the relationship which existed at Oxford and Cambridge 'between the College of Physicians, and the higher classes of the community', a relationship which he held largely accounted for the high status of the physician in the wider society. The central importance of
the close relationship between the College and the universities at Oxford and Cambridge thus lay in the way in which this relationship confirmed the dignity and the status of the physician as a gentleman; the fact that there was no regular teaching of medicine in these universities until the middle of the nineteenth century was, as far as the College was concerned, a consideration of quite secondary importance.\textsuperscript{12}

In marked contrast to the physician, the surgeon had traditionally been regarded as a craftsman rather than a gentleman and, as befitted one who practised a craft, the surgeon received his training by apprenticeship. This training was practical rather than theoretical for, as Newman has noted, the surgeon 'was trained to be a skilful practitioner, not a learned one, and for that reason a university education was not held to be appropriate'.\textsuperscript{13}

The craft origins of surgery were also clearly evident in the fact that, until the middle of the eighteenth century, the surgeons were united with the barbers in the Company of Barber-Surgeons. It was not until 1745 that the surgeons broke away to form a separate Company of Surgeons, but the history of this new company was a relatively short one, for after what Cope has called an 'inspired existence'\textsuperscript{14} of some fifty years, the Company was dissolved following a period of mismanagement of its affairs and shortly afterwards, in 1800, the surgeons were granted a new charter which established the Royal College of Surgeons of London. All practitioners who passed the examinations of the College were admitted as members, but the ordinary members were not allowed to participate in any way in the management of College affairs. The entire government of the College was in the hands of the twenty-one members of the Court of Assistants (renamed the Council in 1822), a body which was able to renew itself by co-option. This structure of government had, in fact, been laid down by the act of 1745 which established the Company of Surgeons, and was taken over without modification by the newly formed Royal College of Surgeons in 1800.\textsuperscript{15}

The third of the medical corporations — and the lowest in status — was the Worshipful Society of Apothecaries. The Society had been formed in 1617 by the grant of a charter
from James I, which separated the apothecaries from their former association with the grocers. The charter of the Society required seven years' apprenticeship to a member as an essential qualification for admission to the freedom of the company, and stated that at the end of seven years, 'every such apprentice... shall be examined, proved and tried concerning the preparing, dispensing, handling, compounding of medicines'. At this time the work of the apothecary — at least as far as medicine was concerned — was limited to the preparing and dispensing of medicines, but by the early part of the eighteenth century the apothecaries had successfully expanded the scope of their work to include medical as well as pharmaceutical practice, and had won legal recognition of their right not only to dispense, but also to prescribe medicines. Despite this change in the apothecaries' practice, however, the Society retained throughout the eighteenth and nineteenth centuries a constitution more typical of a city trading company than of a professional organisation, and in the 1820s, the Lancet disparagingly referred to the Society of Apothecaries — not entirely without justification — as 'these incorporated shop-keepers'.

As was the case with the other two medical corporations, those who held a licence to practise from the Society had no legal right to participate in the management of the affairs of the Society, for the government of the Society was vested entirely in the hands of the twenty-one members of the Court of Assistants, including a master and two wardens, a body which renewed itself by co-option.

From this brief discussion, it is evident that this tripartite structure of physicians, surgeons and apothecaries was clearly institutionalised in the separation between the three major medical corporations. Moreover, it is important to remember that these professional divisions were also clearly recognised in English law, for throughout the first half of the nineteenth century each of the three grades of medical practitioners had certain privileges and certain limited spheres of practice which were legally defined. In this context, it is important to note that the general concept of the qualified or registered medical practitioner had no place in English law prior to the Medical Act of 1858; instead there were
separate laws relating to physicians, to surgeons and to apothecaries.

The clearest contemporary statement of the laws relating to medical practice is probably that contained in J. W. Willcock's *The Laws Relating to the Medical Profession*, published in 1830. As we have already noted, Willcock pointed out that physicians, surgeons and apothecaries constituted the only legally recognised orders of the medical profession, and he went on to note that of these three groups physicians were 'the first class of medical practitioners in rank and legal pre-eminence'. Under an Act of 1540, physicians had been given the right to practise physic in all its branches, amongst which surgery was included. However, the disdain which physicians, as a body of learned men, felt for manual work had led to a considerable contraction in their sphere of practice; and throughout the eighteenth and early nineteenth centuries the practice of the physician was 'universally understood, as well by their college as the public, to be properly confined to the prescribing of medicines to be compounded by the apothecaries; and in so far superintending the proceedings of the surgeon as to all his operations by prescribing what is necessary to the general health of the patient, and for the purpose of counteracting any internal disease'. The legitimate sphere of practice of the physician thus revolved essentially around the twin tasks of diagnosing internal disease, and of prescribing an appropriate remedy; what was regarded as the manual work involved in surgical procedures and in the dispensing of medicines was to be left to the lower orders of the profession.

The laws defining the sphere of practice of the surgeon were a little more complicated. Willcock held that the 'peculiar practice' of the surgeon 'consists in the use of surgical instruments in all cases, and in the cure of all outward diseases, whether by external applications or by internal medicines'. However, he went on to note that several diseases which were sometimes regarded as internal complaints had been recognised by the legislature, or by the charters granted to the surgeons, as falling within the scope of practice of the surgeon. Among these diseases Willcock listed 'the pestilence, syphilis, and such other contagious
infirmities; letting of blood in all cases, and drawing of teeth, customable diseases, as women's breasts being sore, a pin and web in the eye, uncomes of hands, burnings, scaldings, sore mouths, the stone, strangury, sanceline and morphew, and such other diseases, apostemations, and agues; all wounds, ulcers, fractures, dislocations and tumours.  

From this it is clear that the proper sphere of practice of the surgeon was by no means confined to the use of the knife in surgical operations. The legally defined sphere of practice of the surgeon was, nevertheless, a limited one. Thus, in general, the treatment of what were regarded as 'internal' as opposed to 'outward' disorders was held to fall within the legal province of the physician rather than that of the surgeon. This legal principle was upheld in 1828 when a member of the Royal College of Surgeons was nonsuited in his claim for charges for medicines supplied to and attendance upon a patient who had contracted typhus fever, since it was ruled that typhus was a medical and not a surgical disease, and therefore not within the province of the surgeon. The trial judges emphasised the fact that there was a legally defined division of labour within the profession, and that each grade of practitioner was responsible for only a limited area of practice. Thus Chief Justice Best stated that 'I cannot admit that the legislature intended to give surgeons the privilege of practising in physic as well as surgery.... For some disorders relief is sought from medicine, for others from topical applications. A different education is necessary to prepare men to undertake the cure of either of these descriptions of complaints.... The first description belongs to the physician and the apothecary; the second to the surgeon.  

As we have already indicated, the law relating to apothecaries had undergone an important change in the early years of the eighteenth century. However it is clear that although apothecaries had won the legal right to prescribe medicines in the celebrated Rose case of 1703, the dispensing of medicines continued in law to represent an essential part of the apothecary's duties; indeed the dispensing of medicines became an even more central part of the apothecary's duties following the passage of the Apothecaries' Act of 1815, for
clause 5 of the act made it an offence for an apothecary to refuse to make up, or deliberately to make up incorrectly, the prescription of a physician. The dispensing aspects of the apothecary's role were clearly brought out by Willcock, who wrote that their 'proper practice consists in preparing with exactness, and dispensing, such medicines as may be directed for the sick by any physician lawfully licensed to practise physic', although he also went on to point out that apothecaries were 'also at liberty to administer medicines of their own authority, and without the advice of a physician'.

The fact that apothecaries were under a clear legal obligation to dispense faithfully the prescriptions of physicians was of considerable importance within the context of the hierarchy of the medical orders, for this legal obligation served not only to emphasise the apothecary's close association with what were regarded as the trading or shopkeeping aspects of medicine, but more specifically, it also served to define in a quite unambiguous way the subordinate position of the apothecary in relation to the physician.

Thus throughout the first half of the nineteenth century, qualified medical practitioners in England were divided into three formally separated and legally distinct status groups, and the separation between these groups has sometimes been described in terms of the separation between the 'profession of physic', the 'craft of surgery' and the 'apothecary's trade'. However, whilst it is in some respects useful to classify practitioners in this way — such a classification does, for example, serve to draw attention to a number of very important aspects of the institutional structure of the profession — it may nevertheless be argued that this tripartite classification of practitioners gives us what is, in many other respects, a very misleading picture of the everyday structure of medical practice in the rapidly changing social world of early nineteenth century England. This problem will be explored in more detail in the next chapter.
2.

The Changing Structure of Medical Practice in the Early Nineteenth Century

As we have seen, the formal structure of the medical profession in the first half of the nineteenth century constituted an hierarchical structure, with a clear and legally defined division of tasks and of status between physicians, surgeons and apothecaries. Given this situation, it is not perhaps surprising that medical historians have generally described the medical profession during this period in terms of this tripartite institutional structure. However, this tripartite classification of practitioners can be very misleading if it is assumed that these professional divisions corresponded to what practitioners actually did in the day-to-day practice of their profession, rather than simply to their formal or legal status. Indeed, it may be argued that the key to understanding many important aspects of the development of the medical profession in the early nineteenth century lies precisely in a recognition of the fact that this tripartite classification no longer bore any clear relationship to the everyday structure of medical practice. In order to understand this point more fully, it is necessary to direct our attention away from the sort of questions with which we have hitherto been concerned — questions relating largely to certain highly formal aspects of the structure of the medical profession — and to direct our attention towards an examination of what practitioners actually did in the routine day-to-day practice of their profession. If we do this then, as Holloway has noted,1 we begin to get a rather different picture of the structure of the medical profession in the early nineteenth century.

According to the tripartite classification of practitioners, physicians were traditionally held to be scholars and gentle-
men who possessed a university medical degree and confined their practice to internal medicine. According to Dr Newman, they 'used their heads not their hands', and they 'advised rather than did'. Their fees were charged for advice only; they wrote prescriptions for the appropriate medicines, which were then dispensed by an apothecary.

There is, however, little evidence to suggest that many physicians were able to confine their practice to advising and prescribing in this way. Thus in 1834, John Sims, physician to the St Marylebone Infirmary, pointed out to the Select Committee on Medical Education that 'there are very few physicians who practise as such', and he added that 'the principal part of the practice is in the hands of the general practitioners'. Thirteen years later, Professor Christison held that there were a great many physicians practising in England as general practitioners; the title of MD, he said, particularly in the provinces, did not exclude the practice of surgery by a member of the College of Physicians.

There is, in fact, good reason to believe that, especially in the provinces, there were many physicians whose practice included surgery and midwifery, as well as pharmacy. In the north of England, in particular, there were numerous physicians holding Scottish degrees who were engaged in general practice. In 1847 James Bird pointed out that 'Ever since the year of 1815, there has been a bone of contention between the Scotch and Irish graduates and the Society of Apothecaries, because the Scottish and Irish graduates in general practice objected to the fact that under the terms of the 1815 Apothecaries' Act they were required to pass the examination of the Society of Apothecaries or risk prosecution for illegally practising as apothecaries. Readers of Trollope will recall that Dr Thorne, although a graduated physician, took over the practice of a 'humble-minded general practitioner' in Greshamsbury, and that the Doctor 'As was then the wont with many country practitioners . . . added the business of a dispensing apothecary to that of physician'.

General practice amongst physicians was not, however, confined to country districts, or to the provinces, for in London, Scottish educated physicians were in general practice.
in sizeable numbers from the 1760s onwards. There is little doubt that this practice became much more common in the first half of the nineteenth century. Thus by the early 1830s, even the most eminent physicians in London 'did not scruple to take fees in surgical cases'. A few years later Professor Christison pointed out that 'it is very well known that at one time no physician would practise even the simplest operations in surgery, but I believe the whole profession has recovered from that delusion, and that even the purest physician in London will practise the minor operations of surgery when necessary'. In 1834, Neil Arnott, a licentiate of the Royal College of Physicians, held that so many physicians were engaged in general practice that 'before long the body called physicians will wear out'.

If we now consider the situation of those practitioners who were legally designated as surgeons it is clear that, as in the case of medicine, it was becoming increasingly difficult to preserve surgery as a pure branch of practice. When the Company of Surgeons was founded in 1745, the Company insisted on 'being now of no trade but of the profession of Surgery only', and the emphasis on pure surgery was taken over by the Royal College of Surgeons on its foundation in 1800. Yet in 1834, Benjamin Brodie pointed out that of surgeons practising in England, 'only a limited number can confine their practice to surgery, even in London, and very few, if any, can do so in the country', and he went on to observe that over the previous fifty years the practice of the physician and the surgeon had become increasingly intermingled. Sir Anthony Carlisle pointed out that the most eminent surgeons in London practised not only surgery, but medicine too, and he admitted that he saw as many patients 'in the character of a physician, as of a surgeon'. He held that the 'distinction between what ought to belong to a physician, and what belong to a surgeon, are quite undefinable'.

Numerous witnesses who gave evidence to the 1834 Select Committee on Medical Education agreed that it was no longer possible to draw any clear distinction between medical and surgical practice. Thus John Scott, surgeon to the London Hospital, stated that the ancient boundaries of practice were entirely broken down, while James Wardrop,
a former surgeon to the king, held that it was highly desirable that physicians and surgeons no longer confined their practice to a single branch of the profession. Indeed in the first half of the nineteenth century it was becoming increasingly rare, even amongst the leading surgeons in London, to find any who confined their practice to surgical cases. Thus George James Guthrie, who was on two occasions president of the Royal College of Surgeons, stated that when called in to consultation he did not usually ascertain beforehand whether it was a medical or surgical case. Asked if, when called into a case, he found it to be internal without any external appearances, he would decline to accept it, Guthrie stated, 'If I thought I was capable of curing the disease I should attempt it; if I thought I was not, I should desire them to send for some one else.' Honoratus Leigh Thomas, who, like Guthrie, was president of the College of Surgeons on two occasions, was often called into consultation by J F Clarke for medical cases. Clarke wrote that Thomas was a poor surgeon, but that he was a 'shrewd practitioner in medical cases to which his practice was mainly limited'. Perhaps the most celebrated of all nineteenth century surgeons was Sir Astley Cooper, yet not even he limited his practice to surgical cases. His biographer tells us that whilst Cooper was lecturer on surgery at St Thomas's Hospital, he encouraged poor patients to come to his home for gratuitous advice; in this way he was able to maintain a supply of interesting cases for the hospital. As an inducement to the poor to come to him, Cooper purchased a stock of common medicines, which he bestowed liberally 'on them whose means would not allow them to take his prescriptions to the chemist's shop in the usual way'. There is, then, little reason to doubt the accuracy of James Bird's comment that 'it is difficult to define what pure surgery is. The fellows of the College of Surgeons, if they thought proper to practise as pure surgeons, might call themselves pure surgeons if they pleased; but I think very few of them practise it.'

If the most eminent surgeons in London rarely confined their practice to pure surgery, this was even less common among rank and file surgeons. Thus in 1834, when there were some six thousand members of the College of Surgeons
resident in England and Wales, it was estimated that only two hundred of these confined their practice to surgery; the rest were general practitioners. In the same year, James Wardrop pointed out that 'by far the greater number' of members of the College were in general practice; whilst fourteen years later John Ridout, a fellow of the College of Surgeons, similarly estimated that 'by very far the largest proportion' of members of the College were general practitioners. In 1848 James Bird, a member of the council of the National Institute of Medicine, Surgery and Midwifery, provided the Select Committee of that year with a breakdown of its membership: two thirds of the members of the Institute — an association of general practitioners — were members of the College of Surgeons. That many surgeons dispensed medicines is clearly indicated by the fact that in his evidence before the same committee, Guthrie stated that when he was president of the College of Surgeons, he had offered to compile a register of surgeons who were general practitioners, but had been prevented from doing so because it was argued that he would 'show them up to the apothecaries to be prosecuted if they had not their license'.

There is little doubt that, as Guthrie indicated, there were very many surgeons who acted as general practitioners without holding a licence from the Apothecaries' Society. Equally, there were very many apothecaries who similarly acted as general practitioners without holding a diploma from the College of Surgeons. In 1841, a correspondent of the *Lancet* told of a practitioner in Cornwall who had passed the examination of the Apothecaries' Society in 1828, but had never obtained the diploma of the College of Surgeons, 'nor ever attended a surgical lecture, or the surgical practice of an hospital; nor indeed, ever saw any surgical operation excepting those performed behind the counter of a drug shop — yet he calls himself a "surgeon", has "SURGEON" on his street door, and holds the appointment of a medical and surgical attendant on the poor in this district'. The correspondent went on to enquire whether such practice was illegal, and the *Lancet* correctly replied that there were no laws to prevent apothecaries or anyone else practising surgery. There is little doubt that the vast majority of apothecaries
availed themselves of this opportunity; such examples of
general practice on the single qualification could be multi-
plied at great length.28

Although many general practitioners held only a single
qualification, in most cases from either the College of
Surgeons or the Society of Apothecaries, there is neverthe-
less clear evidence that, especially after the passing of the
Apothecaries' Act in 1815, a growing number of practitioners
did obtain a double qualification in both medicine and
surgery. Thus by 1834, some 3,500 members of the College
of Surgeons also held the licence of the Apothecaries'
Society,29 whilst in 1848 James Bird estimated that there
were between 14,000 and 15,000 general practitioners in
England and Wales, and that 'more than half of the 14,000
possessed the double qualification'.30

There can be little doubt that in the first half of the nine-
teenth century the overwhelming majority of the members
of the College of Surgeons were practising as general
practitioners. Similarly, the vast majority of apothecaries —
and, indeed, very many physicians — were also acting as
general practitioners. This conclusion, as well as the consider-
able confusion surrounding medical practice at this time, is
aptly conveyed by the comment of James Bird that 'Scotch
graduates and Irish graduates, and members of the College of
Surgeons who are not also licentiates of the Society of Apothec-
aries, and licentiates of the Apothecaries' Society who are
not members of the College of Surgeons, are all practising
indiscriminately, as general practitioners in this country, in
medicine, surgery and midwifery'.31 The same point was made
in the draft charter for a proposed Royal College of General
Practitioners, drawn up in the 1840s, in which it was stated
that 'there are now practising in England and Wales as Surgeon-
Apothecaries, or General Practitioners, divers persons who have
obtained the diploma of the College of Surgeons . . . but who
have not obtained a certificate of qualification to practise as
an apothecary from the . . . Society of Apothecaries . . . and
divers other persons who have obtained such certificate of
qualification as aforesaid . . . but who have not obtained the
diploma of the College of Surgeons . . . and divers other
persons who are not authorized by law to practise either as
Surgeons or Apothecaries in England and Wales, but who are legally authorized to practise either as Physicians, Surgeons or Apothecaries in some other part of the United Kingdom.  

From what has been said, it is clear that by the early part of the nineteenth century, the traditional divisions between physicians, surgeons and apothecaries bore little relationship to what practitioners actually did in the day-to-day practice of their profession. This is not to say that these traditional labels ceased to be used as a way of describing medical practitioners, but that in this case, as in many others, changes in terminology lagged behind changes in the structure of the profession, and the traditional terminology was, therefore, misleading. If the terms 'physician', 'surgeon' and 'apothecary' remained common in the medical literature of this period, it was becoming increasingly difficult to identify more than a handful of 'pure' practitioners in any branch of practice.

During this period, as Holloway has pointed out, the significance of these traditional professional divisions was increasingly being eroded as a new professional structure, based on the modern differentiation between general practitioners and consultants, began to emerge. Moreover, as practitioners increasingly came to identify with those who practised as they did, rather than with those who simply held a similar legal status, so the division between general practitioners and consultants increasingly became the major de facto line of division within the profession in the first half of the nineteenth century.

Perhaps the clearest contemporary analysis of these changes within the structure of the profession was contained in an essay published in The London and Provincial Medical Directory for 1847. The author began by describing what he called 'The Former Constitution of the Profession' in terms of the three traditional 'orders' of medical practitioners:

The Physician, the Surgeon, and the Apothecary mark its sub-divisions; and law and custom would seem distinctly to have defined the position and duties of each class. It is needless to observe, however, that practically this classification has become almost obsolete. The nomenclature alone remains in force, and its inapplicability to the existing state of things constitutes an admirable argumentum ad
absurdam for the reorganization of the profession. In times past, these several practitioners, in their various grades, were no doubt equal to the sanatory requirements of the people; ... in the present age, the public, advanced in knowledge and power, perceive that they are considerably benefitted by a departure from the economy of the profession as ordered of old. A change, accordingly, is now in progress, which, like all transitions, is marked by a confusion of position and character among individual members...

If we look around, indeed, it will be found that the Physician, the Surgeon, and the Apothecary, as distinct and separate practitioners, exist in but little more than their several designations. The many animadversions that appeared upon the publication of the case of a Surgeon, whose life was said to have been lost through the professional fastidiousness of a late president of the College of Physicians refusing to bleed, proclaimed the sense of the thinking public on such obsolete nonsense as the non-interference of physicians in other than medical cases; whilst Surgeons and Apothecaries are now daily and hourly called in to cases requiring prompt and unassisted action, in which, without a full knowledge of the practice of physic, they would be worse than useless...

The author then went on to examine 'The Present Constitution of the Profession', and he pointed out that with the breakdown of the tripartite structure, medical practitioners were being divided into what he called 'two fundamental orders'. Thus 'whilst Physicians, and Surgeons, and Apothecaries, appear to be so vitally interested in the continuance of useless titles, they really are, by the force of a public convenience they cannot withstand, being gradually classed into Consulting and General Practitioners...'

Thus in the first half of the nineteenth century, the traditional professional divisions were increasingly being eroded and replaced by the modern division of the profession into consultants and general practitioners. The term 'general practitioner', which itself reflected the development of a new social role, appears to have come into use in the
early 1820s — a considerable time, it should be noted, after the role of the general practitioner first emerged — and from about 1830 onwards the title 'general practitioner' is regularly encountered in the medical journals. As we have already seen, numerous witnesses who gave evidence to both the 1834 and 1847-8 Select Committees relating to the medical profession pointed out that the vast majority of medical practitioners were in fact engaged in general practice, and by the mid-1830s, general practitioners probably provided some ninety per cent of the qualified medical care available in England. We have also seen that the general practitioner may have been the holder of a university medical degree, a diploma from the College of Surgeons, a licence from the Society of Apothecaries, or any combination of these. Whatever qualification he held, it was the general practitioner who had emerged as the 'ordinary attendant in private life' or, as another contemporary observer put it, it was the general practitioners who were employed 'on ordinary occasions, and to whom the great majority of society look in the first instance for assistance'. In 1841, it was held that 'Nine-tenths of the public must ever fall under the charge of the general practitioner'.

The number of consultants was, of course, very much smaller than the number of general practitioners. The author of the article in the London and Provincial Medical Directory previously cited held that the consultant was a practitioner of 'superior rank' who acted as 'the extra-ordinary adviser in difficult cases', whilst another author, writing in the Quarterly Review in 1840, defined consultants as those practitioners who were 'called into consultation in rare, difficult, and dangerous cases, in all classes of society — at the same time that their opinion is sought in cases of less urgency among those who have the advantage of ease and affluence'. As we shall see, almost all consultants held appointments at the major voluntary hospitals, and there thus existed a clear institutional basis for the separation between consultants and the rank-and-file general practitioners; indeed the division between those practitioners who held hospital appointments, and those who did not, was to emerge as an increasingly important line of
cleavage within the profession in the first half of the nineteenth century as the traditional professional divisions increasingly broke down.

Although the very complex processes which gave rise to these changes in the structure of medical practice are by no means wholly understood, it is clear that these changes within the profession cannot be adequately understood without reference to other changes which were taking place in the wider structure of society, for the medical profession — like virtually all other institutions — was profoundly affected by those broader social changes which were associated with the process of industrialisation; in this respect, it may be said that, in the first half of the nineteenth century, the medical profession began to lose many of those features which were characteristic of occupations in pre-industrial England, and increasingly began to develop those features which we have come to recognise as the distinguishing characteristics of modern professions.

Perhaps the first point to note in this context is that, in order to understand the erosion of the traditional professional structure, it is necessary to appreciate that the three traditional ‘orders’ of the profession constituted not merely an occupational division of labour but that, as Peterson has noted, they also constituted a ‘social division of medical practitioners into three status groups or estates’. Estate systems of stratification are characterised not merely by a system of differential statuses — this is, of course, common to all stratification systems — but by the fact that the status and the rights and duties of each group are defined in law, and by claims to traditional and historical legitimacy of privileges on the part of the higher estates. As many writers have pointed out, estate systems of stratification of this kind are characteristic of pre-industrial rather than of industrial societies and in this sense, the three ‘orders’ of the profession constituted what Peterson accurately describes as a 'pre-industrial form of social structure and stratification'.

The pre-industrial character of this stratification system may perhaps best be illustrated by the fact that, as we noted in the previous chapter, the highest rank within the
profession — the fellowship of the Royal College of Physicians — was virtually limited to graduates of Oxford and Cambridge, despite the fact that there was no regular teaching of medicine in these universities until the middle years of the nineteenth century. The poor quality of medical education in those universities was not, however, held to be a fact of any great importance as far as the Royal College was concerned, for the status of the physician had traditionally been based overwhelmingly on his claim to be a gentleman rather than a technical expert.

In this respect, the position of the eighteenth or early nineteenth century physician was quite different from the position of those involved in professional occupations in modern industrial societies, for modern professions base their claim to high status and to professional autonomy primarily on their claim to specialised occupational skills and knowledge. In the eighteenth century however — indeed, right through to the middle of the nineteenth century — the dominance of physicians within the medical profession, as well as their high status within the wider society, was rarely, if ever, justified in these terms. The usual line of defence was that taken by Burrows when, as late as 1847, he spoke of 'the great advantages which result to society from there being an order of men within the profession who have had an education with the members of other learned professions; from a certain class of the medical profession having been educated with the gentry of the country and having thereby acquired a tone of feeling which is very beneficial to the profession as a whole." It was this imprecisely defined but nevertheless crucially important 'tone of feeling', rather than the possession of occupational skills and knowledge, which was the hallmark of the gentleman physician. As Elliott has noted, the 'performance of the professional function appears to have been a less important aspect of the professional role than the ability to live a suitably leisured and cultured lifestyle'. A similar point was made long ago by Carr-Saunders and Wilson who, in their classic study of the professions, drew attention to the fact that the leading eighteenth century physicians were 'remarkable for their literary tastes and their association with the world of wealth rather than for pro-
essional skill or scientific eminence', and they went on to note that the lifestyle expected from the physician involved participation 'in the ample life of the great houses where elegance and wit were pursued'.

The physicians' dominant position within the profession was thus based on a very traditional claim to status which stressed their close association with the dominant groups — particularly landed groups — in pre-industrial England; it is precisely because of this fact that Elliott describes the position of the eighteenth and early nineteenth century physicians in terms of 'status professionalism' rather than in terms of the more modern form of 'occupational professionalism', for the specific nature of their occupational tasks or skills played little part in their claim to status or prestige.

It is also important to appreciate that the traditional tripartite division between physicians, surgeons and apothecaries cannot be understood as a simple technical division of labour, for as Carr-Saunders and Wilson have again pointed out, this 'form of organisation was not dictated by the nature of medical technique'; indeed, in the early nineteenth century there was a growing realisation, which was frequently and forcefully expressed in the columns of the Lancet, that this tripartite division of labour actually militated against the full employment of the medical knowledge of the time. Rather, this professional division of labour must be understood as an aspect of what we have argued was a pre-industrial hierarchy of rank and status. In this context, it is important to bear in mind that, as we have already seen, the dominant groups within the profession — like the dominant groups within the wider society — did not derive their high status primarily from the work which they did, for work had not yet come to be the major determinant of social status which it subsequently became with the development of a more complex, industrial society. Rather, it was the status claimed by particular groups of practitioners — for example, the physicians' claim to be gentlemen — which determined the sort of work they allowed themselves to do, and the sort of work which was to be left to the 'lower orders' of the profession.
This point may be illustrated by reference to the long-standing division between medicine and surgery, a division which has to be understood primarily in terms of the fact that for an extraordinarily long period, medicine remained under the influence of the aristocratic tradition which shunned work with one's hands as degrading. As Weber has noted, this prejudice against manual work is common amongst privileged status groups, and the insistence of the College of Physicians on a clear separation between medicine and surgery must be understood in the context of the College's policy of maintaining the dignity and the status of the physician by avoiding anything which bore the stigma of manual work. Similar considerations of status underlay other aspects of the division of labour within the profession. Thus not only the Royal College of Physicians, but also the Royal College of Surgeons, refused to have anything to do with the practice of midwifery, which they regarded as a particularly undignified and low status form of manual work, whilst both Royal Colleges similarly set themselves clearly apart from the practice of the apothecaries, for the work of the apothecary carried a double stigma associated both with manual work and with 'trade'.

This tripartite division of labour did not, then, derive primarily from technical considerations relating to the nature of medical work, but rather it has to be understood as an aspect of the system of rank and status which had been institutionalised within the medical profession since the early sixteenth century. By the early years of the nineteenth century both this traditional hierarchy, dominated by the figure of the gentleman physician at its apex, and the division of labour which was an aspect of this hierarchy were increasingly being undermined; with the development of a more complex, industrial society, new sources of status and new patterns of stratification began to emerge in the wider society, and the dominance of traditional aristocratic attitudes towards work was increasingly being challenged by a rising and pragmatically oriented middle class. These changes within the wider society were closely associated with changes within the structure of the medical profession and, in particular, with what Elliott describes as the transition from
'status professionalism' to 'occupational professionalism'. Thus whereas, in the eighteenth century, 'the status professions were able to maintain a foothold among the ranks of the gentlemen by glossing over their work responsibilities and emphasising the leisured and honourable life-style which their members could adopt, in the nineteenth century the possession of occupational skills and knowledge came to be seen as an alternative and increasingly important source of social status.

This new form of occupational professionalism developed only slowly amongst the old established elite groups within the profession, who continued to emphasise their more traditional claims to status. Few rank and file practitioners, however, could lay claim to either a classical education or a cultured and leisured life style and it was amongst this section of the profession that greatest stress came to be placed on the possession of occupational skills as an alternative claim to status. This new emphasis on the performance of occupational tasks — on medical work per se — rather than on the more traditional 'non-work' aspects of the doctor's role, was of major importance, for it gave rise to a radical and particularly telling critique of the traditional tripartite division of labour within the profession. Increasingly, for example, a growing number of practitioners began to point out that this division of labour did not derive from the nature of medical work itself, but that it had its origins in what the Westminster Review called the 'spirit of caste and false notions of dignity'. Perhaps more importantly, however, since this related directly to the efficient performance of medical work, there was also a growing realisation that this tripartite occupational division of labour actually inhibited the development of both medical science and medical practice. Thus the Lancet argued, in its own typically forceful style, that by maintaining what was increasingly seen as the outmoded status distinction between medicine and surgery, the Royal Colleges had 'actually cut the body of the science in two, and sent each half hopping off on one leg, telling us all the while, with infinite gravity, that medicine will get on much better that way, than if it remained a whole body and walked upon two legs'. The Westminster Review
similarly drew attention to the 'practical inseparableness' of the different branches of practice and stated that the 'division of the profession into physicians, surgeons, and apothecaries, we cannot but regard ... as inimical to the progress of medical science and the public welfare'.

Within this context, those senior members of the profession who tried to maintain a clear separation between the different branches of practice were portrayed as men who were more concerned with the maintenance of traditional status divisions — the 'false notions of dignity' — than they were with meeting the health care needs of the population. The Royal College of Physicians, for example, which refused to allow its fellows to practise what it regarded as the manual art of midwifery, was lambasted in the following terms: 'notwithstanding the fact that women will persist in bringing children into the world, and that many of the gravest maladies which flesh is heir to consist of organic or functional diseases of the uterine organs, the College of Physicians was of opinion that the practice of midwifery and the collateral branches of that department of the profession is a degradation from which its fellows must be sacredly guarded'.

The increased emphasis which came to be placed on the acquisition of occupational skills and on the performance of occupational tasks involved, at first implicitly but later quite explicitly, a radical re-evaluation of the status and significance of different kinds of medical work. Thus whereas certain branches of practice had traditionally been seen as ungentlemanly and therefore a bar to high status within the profession, by the early nineteenth century the growing number of practitioners who united all branches of practice saw the fact that they did so as something which both extended their sphere of competence and increased their usefulness as practitioners and, as such, this was increasingly seen not as a bar to status, but as a positive claim to status. As one contemporary put it, general practitioners united all the three branches of surgery, medicine and pharmacy, a circumstance which, he claimed, 'renders them, it must be allowed, the most efficient part of the profession', and he went on to argue that the 'General Practitioner seems to me to possess that sort of superiority, when compared to
the exclusive Physician, which common sense always allows to the practical in preference to the theoretical part of any science whatever. In these terms, both the traditional status hierarchy within the profession and the division of medical labour associated with that hierarchy were increasingly challenged.

It is clear that these changes in the structure of the medical profession were closely associated with the relative decline of traditional sources of status and the emergence of a new form of professionalism in which the performance of occupational tasks and the possession of occupationally relevant skills and knowledge came to play an increasing part in the determination of status. There is, however, a further way in which these changes within the structure of the profession were related to changes in the stratification system of the wider society; for the development of general practice appears to have been, at least in part, a response to the growth of what was largely a middle class demand for family medical care. Early in the nineteenth century, Robert Masters Kerrison, writing on behalf of the apothecary as a general practitioner, drew attention to what he called 'the augmentation of the middle orders of the community', and he pointed to the importance of this development for medical men in the following terms:

The state of the Society at the establishment of the Royal College of Physicians was widely different from what it is at present. The ancient nobility, and a few rich citizens, constituted one class; while the servants and dependents of the former, added to the workmen and labourers of the latter, formed another class. The noble and wealthy could afford to fee their Physicians; and it was not usual, in those days to legislate for the wants and convenience of others.

The progress of commercial prosperity, since that time, has so greatly multiplied, that it may be almost said to have created a third, which is now the most numerous class of people — the middle order of society. . . . One effect of this augmentation of the middle orders of the community was a proportionate increase of sickness,
amongst people, who were unable to procure medical aid, by feeing Physicians as often as their situation required medical care, and the Members of the Royal College of Physicians, having made no diminution in their accustomed fee, to meet the actual wants of persons in this class of society, they were compelled to resort to others for advice.  

As Holloway has pointed out, this growth of the middle classes resulted in a significant change in the pattern of demand for health care, with a steadily increasing number of middle class families who required health care but were unable to engage consulting physicians and surgeons on the terms traditionally charged. The middle class demand for health care was essentially for medical men who were able and willing to provide family medical care including midwifery and to charge for their services at modest rates; as Rachel Franklin has noted, the 'expansion of the industrial community . . . produced a greater demand less for the highly qualified physician than for the family doctor', a position which came to be filled by the general practitioner.

One key to the rapid growth of general practice in the nineteenth century undoubtedly lay in the fact that general practitioners were catering for what was a rapidly expanding demand for relatively low cost family medical care; certainly it was the opinion of contemporary observers that the pattern of client choices was changing, and that general practitioners were effectively responding to this changing demand. In 1834, for example, George Birkbeck drew attention to 'a great tendency on the part of the public, of late years, to employ the general practitioners', a tendency which he attributed largely to the relatively modest cost of general practitioner care. Thus Birkbeck pointed to 'the change in the condition of society . . . which seeks for its assistance . . . in one individual, rather than in the more expensive form of three'; whilst James Wardrop made a similar point when he argued that the development of general practice was highly desirable 'for the public interests', because it meant that any medical attention which was required could be obtained from 'one competent medical
man, rather than the patient having to be attended 'by a surgeon, a physician, and his apothecary; so that three advisers are paid, instead of one'.

John Sims similarly pointed out that the fees of the general practitioner were relatively modest by comparison with those of the physician; and he also noted that where a medical man was unable to perform minor surgical operations, so that another practitioner had to be brought in, this generally entailed additional expense for the family. It was for this reason, argued Sims, that the general practitioner had a competitive advantage over those practitioners who confined their work to a single branch of practice. Not surprisingly, Sims agreed that 'Families in moderate circumstances will always prefer calling in a general practitioner', for such families preferred to call in a practitioner 'who embraces all, instead of him who can only act in one capacity'. It was this fact, suggested Sims, which had "tended to limit the number" of physicians, and which largely explained the rapid increase in the number of general practitioners.

Although relatively modest by comparison with the fees of the consultant physician and surgeon, general practitioners' fees were still sufficiently high to prevent most working class people from using the services of a general practitioner on a regular basis. For the growing number of middle class families, however, general practitioners offered a form of qualified medical care which was both relatively inexpensive and relatively convenient, and there is little doubt that it was this growing middle class market which provided the basis for the rapid development of general practice. Thus whereas consultant physicians and surgeons, as we shall see, continued to orientate their private practices towards a relatively wealthy, but also relatively small, clientele, it was the general practitioners who were actively involved in exploiting the new and expanding market possibilities opened up by the growth in demand for relatively low cost family care.

The other major change within the structure of the profession during this period was, as we have already noted, the emergence of a class of consultants as a distinct group of practitioners and this process, as both McKeown and Peterson
have pointed out, was closely associated with the development of hospitals in the eighteenth and nineteenth centuries. The growth of the hospital system from the middle years of the eighteenth century has been described by a number of writers,66 and there is no need to repeat here the details of what is, to most historians, already a familiar story. It is, however, important to note that from the middle of the eighteenth century, hospitals came to play an increasingly important part in the provision of health care in the larger urban areas and that, from the early nineteenth century, the hospitals assumed a new significance within the profession as they increasingly emerged as the centres of medical education. As Peterson has noted, these developments—and in particular the emergence of the hospital as the major centre of medical education—opened up a new type of medical career structure in which hospital appointments came to be of increasing importance for those who aspired to reach the top of their profession.67 The importance of hospital appointments in this context will be examined in more detail in the next chapter; for the moment we need simply note that consultants enjoyed considerable advantages over their colleagues in general practice deriving directly or indirectly from their hospital appointments. One important consequence of these changes in medical career structures was that a new line of differentiation began to appear within the medical profession for, as McKeown has noted, increasingly 'the important distinction was then between doctors who were appointed at the large voluntary hospitals, whether as physicians or surgeons, and those who were not'.68 The increasing use of the term 'consultant' to refer to those who held hospital appointments thus 'reflected the development of a new distinction within the medical hierarchy' as 'consultants of the teaching hospitals—whether physicians or surgeons—became recognised as a separate group from the rank and file of medical men'.69 In terms of the development of this new professional structure, the importance of the development of hospitals lay in the fact that they provided a clear institutional basis for the emergence of a type of career structure which set consultants apart as a distinct group of practitioners within the profession.
Thus far we have examined some aspects of the changing structure of the medical profession in the first half of the nineteenth century, focussing particularly on the development of the modern structure of the profession, based on the differentiation between consultants and general practitioners. Our next task is to analyse in some detail the social — including the economic and political — situation of general practitioners and of consultants, and the relationship between these two groups of practitioners. This analysis, it is hoped, will throw some light on other aspects of the development of the medical profession, and in particular on the inter-related problems of intra-professional conflict and the development of the campaign for medical reform, both of which figure prominently in the history of the profession in the first half of the nineteenth century.
WHICHEVER aspect of their situation we examine, it is clear that consultants enjoyed considerable advantages over their colleagues in general practice. As we have already noted, consultants normally held appointments on the staffs of the charitable hospitals of London and the major provincial cities, and since the advantages which they enjoyed derived, in large part, from their positions within these hospitals, it is necessary to examine the network of relationships which centred on these institutions.

In the older endowed hospitals in London, the physicians and surgeons had always received some form of payment for their services, although in the newer hospitals the doctors were generally unpaid. However, the older hospitals had failed to increase their salary rates to take account of the current value of the services they were receiving, and although small payments continued to be made in some hospitals, physicians and surgeons gradually acquired honorary status.

The direct rewards for medical attendance were thus, at best, very modest. However, as hospitals developed as major centres of medical education in the late eighteenth and early nineteenth centuries, the rewards from teaching came to be quite considerable. In 1844, Dr Carus noted that at St Bartholomew's, 'the physicians are not paid, as is the case so frequently in England, but several young men and surgeons attend their lectures, study their treatment of the patients, and pay for this privilege a considerable fee, so that in this way a few thousand pounds are easily made in the course of the year.' During the early 1820s, the theatre of St Thomas's Hospital 'was crowded in every part by upwards
of four hundred students of the most respectable description, all of whom paid three guineas or more, the greater part of which went to the lecturer. In 1816, Benjamin Brodie's income from fees and lectures at St George's Hospital amounted to £1530.

In addition to their lecture fees, surgeons in the larger voluntary hospitals in London often received large fees from apprentices. Sir James Paget recalled that in the 1830s the usual fee for the four or five years' pupilage was 500 guineas and for a resident pupil 1000 guineas. In January 1826, Frederick Tyrrell, a surgeon at St Thomas's Hospital, received £1050 from or on behalf of William Tice James, and four years later Tyrrell received the same sum again when he accepted James Dixon as an apprentice. In December 1825, John Alexander Harper's premium to Aston Key, a surgeon at Guy's, was £1000. In 1822, Edward Stanley, surgeon at St Bartholomew's Hospital, received £700 as a premium on behalf of William Pennington, whilst in the same year William Money received £800 when he accepted Thomas Egerton as an apprentice. When Samuel Solly was apprenticed to Benjamin Travers the fee was 500 guineas, but in 1834 Solly himself required 600 guineas as a premium. The standard fee for an apprenticeship to a leading hospital surgeon in London appears to have been in the order of 500 to 600 guineas; sums in this range were repeatedly paid to Green, Abernethy, Earle and Stanley. Fees in provincial hospitals were lower, but still considerable. In 1815 when Thomas Ash was apprenticed to Samuel Dickenson, surgeon to the Birmingham General Hospital, the premium was £210, whilst the fee for an apprenticeship to one of the surgeons at the Bristol Infirmary in 1813 was 150 guineas.

The direct income from teaching could thus be very considerable. Nevertheless, the greater part of consultants' incomes was derived not from teaching, but from private practice. Here again, an appointment at one of the larger teaching hospitals was a major asset, for many consultants were able to build up lucrative private practices based largely on their success in the hospital. Thus, in the first place, teaching enabled consultants to establish contacts with large numbers of students who in later years sent their own
private patients for remunerative consultations. The value of hospital connections in this context was, for example, clearly recognised by Sir James Paget, who had one of the most profitable practices in London, and who, in his memoirs, drew attention to the 'regularly increasing number of cases to which I was called into consultation . . . especially by old Hospital-pupils who were in large practice'. Secondly, the lay governors of the charitable hospitals were both wealthy and influential; holding an appointment at one of these hospitals meant that there was a good chance of becoming the private medical adviser to the lay members of the board. Thirdly, a hospital appointment was an excellent advertisement in attracting wealthier clients for, as Abel-Smith has noted, it 'became known by private patients that the hospital staffs possessed the most advanced knowledge. Charitable work became the key to fame and fortune. Rather than confining their work to consulting practice, most consultants also acted as general practitioners to the nobility and wealthy merchants. In this capacity consultants, whether physicians or surgeons, practised both medicine and surgery, but rarely pharmacy or midwifery. General practice was frequently financially rewarding; as a writer in the Quarterly Review pointed out in 1840, consultants were the regular attendants 'among those who have the advantage of ease and affluence'. Consulting practice was also lucrative. In 1813, Sir Astley Cooper performed the operation for stone upon Mr Hyatt, a wealthy merchant, for which he received 1000 guineas. The two physicians who attended with him each received £300.

The combined income from teaching, consulting and general practice was often very high. Sir Astley Cooper's annual income was in excess of £15,000, and in 1815 he earned £21,000. Like other consultants, Cooper treated a wealthy rather than a numerous clientele; his biographer recalled that it was not unusual for Cooper to receive only five fees in the course of a morning's work, 'and yet the sum he received might be large, for they almost all paid in cheques'. Although Cooper's income in 1815 was quite exceptional, other consultants earned very large incomes. Between 1824 and 1846, for example, Sir Benjamin Brodie's
earnings varied between eight and ten thousand pounds a year, an income which was more than sufficient to support Brodie in the lavish lifestyle which he favoured; in his later years he invested in a country estate with 450 acres of land. Sir James Paget's earnings at the peak of his career were in excess of £10,000 a year, whilst on occasions John Abernethy also earned £10,000, and Robert Liston nearly £7000 a year. Among the consulting physicians, Matthew Baillie, who was for twelve years physician to St George's Hospital, earned £10,000 a year for many successive years early in the century, whilst in the 1820s and 1830s Sir Henry Halford, for many years the president of the Royal College of Physicians 'made his £10,000 a year regularly'. William Chambers, physician to St George's Hospital, also had a very lucrative practice in London; between 1836 and 1851, his income is known to have ranged between seven and nine thousand guineas a year.

Many consultants thus enjoyed a market situation which was extremely lucrative; as Peterson has noted, with incomes such as these 'medical men in the upper ranks lived comfortably, when not truly lavishly'. In addition to their favourable market situation, however, consultants also held a virtual monopoly of the major political offices within the profession. As we shall see below, general practitioners were effectively excluded from the governing councils of the Royal College of Physicians and the Royal College of Surgeons, and the offices which the consultants held within the Royal Colleges enabled them to perpetuate the advantages which they enjoyed, sometimes at the expense of other members of the profession. Thus in December 1822, the Court of Examiners of the College of Surgeons resolved that only those lectures on anatomy which had been delivered in the winter session would be recognised by the College. The effect of this new regulation was to withdraw official recognition from the courses given during the summer session by excellent teachers in the private schools not attached to the hospitals. At a protest meeting of members of the College of Surgeons, held at the Freemasons Tavern in February 1826, two speakers expressed concern at the effect this regulation was having on Joshua Brookes' famous school in
Great Marlborough Street. Their fears were not unjustified, for as Cope has noted, by this regulation ‘the well-known and popular courses of Joshua Brookes were banned and that celebrated teacher was ruined’. Two years later, the Court of Examiners of the College of Surgeons passed a second regulation which, like that of 1822, had the effect of restricting competition from other teachers, and thus of preserving the very lucrative teaching monopoly of the consultants in the larger hospitals. The regulation of 1824 stated that in future the only schools of surgery to be recognised by the College would be those of London, Dublin, Edinburgh, Glasgow and Aberdeen, and that certificates of attendance at lectures and of attendance upon the surgical practice of an hospital would only be accepted if the teachers and hospitals were in one of the above recognised schools. The Lancet was not slow to draw attention to the way in which these regulations worked to the advantage of surgeons holding appointments at the larger voluntary hospitals. ‘The hospital surgeon,’ it wrote, ‘is the pupil’s master, and pockets the money for his “walking” through the wards, and the same surgeon is the pupil’s lecturer, and pockets the fees for the regular courses. Thus far he filches the fees as surgeon to the hospital, as lecturer on anatomy, as lecturer on surgery, and as demonstrator. Mark further! This surgeon, lecturer and sinecure demonstrator, takes his station amongst the Council of the College of Surgeons, where he manufactures the “regulations” which are to enforce attendance upon his lectures and hospital practice. The Lancet wrote of these regulations that ‘we never beheld any resolutions more hostile to science, or more decidedly avaricious’ and, addressing its words specifically to the Examiners of the College, it pointed out that ‘gentlemen, you have been, or are still, hospital surgeons yourselves, and therefore you have passed this measure for your own advantage, and that alone’. Thus consultants not only found that the economic rewards of their profession were frequently very high, but they also held a virtual monopoly of the key political offices within the profession. These were, however, not the only advantages enjoyed by consultants for, in addition to the
high prestige associated with hospital appointments, consultants also had access within the hospitals to research facilities which were normally unavailable to general practitioners and which, with the development of modern medicine in the nineteenth century, came to be of steadily increasing importance.

If we now examine the situation of general practitioners, it is clear that most rank and file members of the profession had few of the benefits enjoyed by consultants. Unfortunately it is not easy to generalise about the economic situation of general practitioners, since the available evidence on incomes in general practice is very fragmentary. Nevertheless, two points are clear. The first is that the incomes of general practitioners varied considerably, depending on the type of practice. Thus a small practice in a fashionable seaside town or an inland spa town would be worth considerably more than a larger practice in a predominantly working class industrial area. Similarly, a practice situated in a sparsely populated rural area often involved a great deal of work for a comparatively small income. That seaside and spa towns, together with some of the older cathedral cities, offered a better livelihood to medical men is indicated by the fact that throughout the nineteenth century these towns attracted more practitioners in relation to population than did the newer industrial areas or thinly populated rural districts. Medical men tended to go where the returns from practice were greatest.

The second point is that those practitioners with less fashionable practices frequently earned only small incomes. Readers of Thackeray will recall that John Pendennis was a surgeon-apothecary in the west of England and that he had a 'very humble little shop'. He had 'for some time a hard struggle with poverty; and it was all he could do to keep the shop and its gilt ornaments in decent repair, and his bedridden mother in comfort'. It was not until, by accident, he received the patronage of Lady Ribstone, who introduced him into 'the good company of Bath', that he began to prosper. Many practitioners kept open shop in order to supplement their meagre incomes. Thus Pendennis 'not only attended gentlemen in their sick-rooms, and ladies at the
most interesting periods of their lives, but would condescend to sell a brown-paper plaster to a farmer's wife across the counter — or to vend toothbrushes, hair powder and London perfumery'. In 1840, a correspondent of the *Lancet* suggested that practitioners should 'abandon the sale of patent pills, pastilles, perfumery, soap, etc'; a view which derived from the fact that retailing was frequently held to be degrading to members of a profession. Since, however, retailing provided an important source of income for many poorer practitioners, it was a practice which could not be given up without serious financial loss.

Those medical men whose practices were situated in poorer neighbourhoods found it especially difficult to obtain more than a very modest income from medical practice. In 1900 H N Hardy recalled that 'in the early part of the century, medical men were content to accept rates of payment which, though known to be inadequate, were often as much as could possibly be spared from too scanty wages.' This situation persisted, of course, well beyond the early part of the century; in 1875 it was pointed out that a 'medical man, living in a poor part of town, has to find his account amongst a population ill able to bear any charge for medicines and attendance in sickness'. In such neighbourhoods, the problem for medical men, in terms of securing an adequate income, was not simply one of attracting patients from amongst a population which could ill-afford medical care for — difficult though this was — there was still another problem to be overcome: as one practitioner put it, 'to get a patient is one thing; but to obtain the fee quite another.' Non-payment of fees was a major problem for medical practitioners, particularly for those working in poorer districts; in the 1830s, doctors in the poorer parts of Manchester and London could expect to receive only about one-third of their fees.

Whilst those at the top of the profession could accumulate considerable fortunes, the economic situation of the great majority of general practitioners was very much more modest. Some very rough idea of the variation in earning power between those at the top and those at the bottom of the profession may, perhaps, be gauged by the fact that of
the three hundred members of the profession who died in 1858, three left sums in excess of £50,000 and an additional seventeen left sums ranging between £10,000 and £50,000; whilst, at the other end of the scale, more than one practitioner in nine died leaving less than £100. Not surprisingly, perhaps, many poorer practitioners found their incomes insufficient to enable them to make adequate provision, upon their deaths, for their families. The Society for the Relief of Widows and Orphans of Medical Men, which was formed to provide for the families of deceased practitioners who found themselves in straightened circumstances, reported in the early 1840s that ‘one in four of the members of the society has left a widow or orphans claimants on its funds’. Although, as we shall see later, there is good reason to believe that the economic situation of most medical men began to improve quite substantially towards the end of the century, Hardy indicates that financial hardship persisted amongst certain sections of the profession throughout the nineteenth century. Thus at the end of the century there were still three charitable societies in London alone which aimed at ‘relieving cases of pecuniary distress among medical men, their widows and orphans’, a fact which Hardy claimed indicated that ‘in the battle of life but too many practitioners and their families come to grief’.

If the market situation of many general practitioners was not financially very rewarding, this was not however their major complaint. Although comment on their modest financial situation was not infrequent, the major grievance of the general practitioners centred on the relationship between themselves and the medical corporations — in particular, the Royal Colleges. In order to understand the causes of these complaints, we have to relate the policies of the Royal Colleges to the changing structure of the profession outlined in the previous chapter.

The traditional structure of the medical profession had involved the differentiation between three groups of practitioners, namely physicians, surgeons and apothecaries. Corresponding to this tripartite structure, there were three major medical corporations, each with its own charter or Act of Parliament and its own bye-laws, and each granting...
licences to practise in the particular branch of the profession for which it was responsible. Moreover, not only were physicians, surgeons and apothecaries organised in quite separate medical corporations, but the policies of the medical corporations had long been designed to maintain the barriers separating the different types of practitioner and the different branches of practice. Thus throughout the eighteenth century, no apothecary could obtain the licence of the Surgeons' Company without ceasing to be a member of the Society of Apothecaries. Similarly, no apothecary or surgeon could take out a licence from the College of Physicians without relinquishing his membership of the Apothecaries' Society or the Company of Surgeons. Thus in 1756, William Hunter had to pay forty guineas to withdraw from the Company of Surgeons because he wished to take out a licence to practise as a physician; whilst in 1795 the College of Physicians approved the refusal of its president, Sir George Baker, to examine an apothecary who applied for a licence to practise physic, and instructed the officers of the College to prepare a statute authorising the similar rejection of any person employed as an apothecary or surgeon. In the early years of the nineteenth century, Charles Locock was required to disfranchise himself from the College of Surgeons on becoming a licenciate of the College of Physicians, whilst George Mann Burrows had to withdraw from both the College of Surgeons and the Society of Apothecaries before taking out a licence to practise as a physician. In 1834, the College of Physicians had still not modified this regulation, the purpose of which was made quite explicit by the president of the College, Sir Henry Halford. In his evidence to the 1834 Select Committee on Medical Education, Sir Henry said the regulation was maintained because, if applicants for a licence from the College were not required to disfranchise themselves from the other corporations, 'it would diminish somewhat the high respectability of men of education, who stand on the same ground as members of the English Universities.' The object of the regulation was thus quite clear; as Sir Henry put it, 'we wish to keep the practice [of physic] as respectable as possible, and as distinct.'
Throughout the first half of the nineteenth century, both Royal Colleges persisted in this traditional policy of trying to maintain the separation of medicine and surgery and, in particular, of rigidly separating both these branches of practice from what the Colleges regarded as purely manual or trading activities. To further this policy of maintaining the purity of medicine and surgery both Royal Colleges excluded from their governing councils those who practised as apothecaries or who practised midwifery. In the College of Physicians, this had traditionally been effected by restricting the fellowship of the College to graduates of Oxford and Cambridge: that is, to gentlemen by whom the manual work involved in pharmacy and midwifery was seen as degrading. In 1771, however, the bye-laws of the College were revised, and the ban on the practice of midwifery and pharmacy was made explicit. The new bye-laws stated that no person practising midwifery was to be admitted to the fellowship, that physicians practising as apothecaries were not to be admitted, and that fellows who entered on practice as apothecaries were to be expelled.46

In the Company of Surgeons, it had been stipulated by a bye-law of 1748, that 'no person practising as an apothecary or following any other trade or occupation besides the profession ... of a surgeon, shall be capable of being chosen into the Court of Assistants (Council)'.47 This emphasis on the practice of pure surgery was retained by the Royal College of Surgeons on its foundation in 1800. Thus, in his evidence before the 1847 Select Committee on Medical Registration, John Ridout pointed out that the College of Surgeons had persistently shown itself unwilling to undertake an efficient examination with regard to general practitioners as well as surgeons: 'it was proposed in 1812, 1813 and 1814, that they should then undertake the superintendence of the medical as well as the surgical education of the surgeon or surgeon-apothecary; but the opinion of the council at that time was, that they wished to confine their attention to surgery exclusively, and they have continued to express a similar opinion down to the present time.'48

Moreover, like the Royal College of Physicians, the Royal College of Surgeons continued to exclude from its Council
those who practised as apothecaries and those who practised midwifery. Thus in 1834, the president of the College, George James Guthrie, pointed out that 'The Council is selected from those surgeons who practise surgery only. A gentleman is not admissible who practises as an apothecary; and this has been so for a long time, certainly ever since the Act of Parliament separating the surgeons from the barbers. It is contrary to the bye-laws to elect into the Council a gentleman who practises as a midwife; nor is any one eligible unless he practises surgery only. It is open to all persons of that description.' However, as Guthrie himself acknowledged, there were only about two hundred persons 'of that description' in the whole of the membership of the College; the remaining six thousand or so members of the College resident in England and Wales were excluded from membership of the Council on the ground that they were 'persons who practise as surgeon-apothecaries' or, as they were increasingly coming to be called, general practitioners. Thirteen years later, Benjamin Travers, who had by that time taken over as president of the College, indicated that the College had not changed its attitude towards those who practised as surgeon-apothecaries. There was, said Travers, 'not perfect eligibility to the Council; a man, for example, must have nothing to do with the practice of pharmacy to take a seat in the council'.

Nor did the Royal Colleges change their attitude towards the practice of midwifery which, like the dispensing of medicines, necessarily formed an important part of the practice of very many general practitioners. Thus in the 1820s, after a suggestion that the Royal College of Physicians should examine in midwifery, a committee reported to the College, giving a plethora of historical information tending to show that 'the object of the College has been to confine the fellows to the pure practice of physic'. In 1834, the attitude of the president, Sir Henry Halford, was equally uncompromising. Thus he said of midwifery that

I think it is considered rather as a manual operation and that we should be very sorry to throw anything like a discredit upon the men who have been educated at the
Universities, who have taken time to acquire their improvement of their minds in literary and scientific acquirements, by mixing it up with this manual labour. I think it would rather disparage the highest grade of the profession, to let them engage in that particular branch, which is a manual operation very much.®®

The admission to the fellowship of those who practised midwifery was, said Halford, something which 'has never been done; it has always been objected to; there is a mixture of manual operation, with the practice of physic, which we think does not quite accord'.®® Halford's sentiments were echoed by James Wilson, a fellow of the College of Physicians, who was equally adamant that midwifery could not be accepted as a legitimate part of the practice of the physician. 'With no disparagement at all to that branch of the profession,' said Wilson, '... I would not admit a physician actually practising midwifery to the fellowship.' If such people were admitted, he said, 'the effect would not be at all conducive to the dignity of the College', with the result that the College 'would rather lose consequence in public estimation'.®®

The College of Surgeons similarly maintained a hostile attitude towards the practice of midwifery. Thus Guthrie concluded his observations on those who practised midwifery with the comment that 'with all possible respect for this class of gentleman, I must say, that I should be exceedingly sorry to see the first accoucheur in this town president'.®® There was, of course, no possibility of such a situation arising since, under the bye-laws of the College, those who practised midwifery were not even eligible for membership of the Council.

In the College of Surgeons, the official reason for the exclusion from the Council of those who acted as apothecaries and those who practised midwifery was that such practitioners had no time to devote to specialising in the study of surgery.®® Underlying this policy, however, both in the Company of Surgeons and later in the Royal College of Surgeons, was a concern to improve and later to maintain the status of surgery by insisting on a clear separation between surgical
work and what were considered to be lower status branches of practice; as one observer bluntly put it, both the College of Surgeons and the College of Physicians had adopted an 'exclusive system . . . in order to gratify the spirit of caste, by keeping their respective departments "respectable and distinct". Moreover, the leading surgeons became increasingly concerned to maintain the practice of surgery as a 'respectable and distinct' branch of practice as the status of surgery itself began to improve markedly from the latter part of the eighteenth century, a process which was both recognised and further enhanced by the grant of a royal charter to form the Royal College of Surgeons in 1800. This rise in the status of surgery may, in part, have been associated with certain improvements in surgical technique, but it was probably more closely related to the fact that many leading surgeons acquired a new status by virtue of their association with the increasingly important hospital sector. Thus, as the major division within the profession increasingly came to be that between practitioners who held hospital appointments and those who did not, so all hospital practitioners, whether physicians or surgeons, increasingly came to enjoy a common status and common privileges by virtue of their hospital appointments. Whatever the precise reasons for this process, however, it is clear that from the latter part of the eighteenth century, the status of the surgeon began to improve quite markedly, and that by the early part of the nineteenth century, the status of the leading hospital surgeons was not very different from that of the leading physicians. Thus in the early 1740s the status of surgery had been very much lower than that of medicine, the surgeons at that time still being associated with the barbers in the Company of Barber-Surgeons. Less than a century later, however, the status of surgery had risen so considerably that Paget was able to recall that when he entered St Bartholomew's in 1834, 'the main interest and power of the Hospital were surgical . . . the teaching and importance of medicine were made to seem very inferior to those of anatomy and surgery; and the contrast was sustained in many things outside the hospital. In the College of Physicians, the problem had been not so much to raise the status of physicians, as to maintain the high
status which they had for long enjoyed. As we have seen, the physician had traditionally enjoyed the status of a learned and cultured gentleman; and the ban on the practice of midwifery and pharmacy for those who aspired to the rank of fellow was aimed at preserving this status by obliging fellows to abstain from those tasks which were considered to involve manual work. As the president of the College indicated, the College had no intention of allowing the status of the physician's practice to be threatened by, as he put it, 'mixing it up with this manual labour'.

Thus throughout the first half of the nineteenth century, both Royal Colleges persisted in their traditional policies of trying to maintain the purity of their respective branches of practice. This point is of major importance, for what the Royal Colleges were, in effect, trying to do was to maintain the traditional structure of the profession based on the distinctions between physicians, surgeons and apothecaries, at the very time that changes within the wider structure of society were bringing about changes within the structure of the profession itself. As we have seen the tripartite structure of the profession was increasingly breaking down and being replaced by a new structure, in which the two major groups were general practitioners and consultants. Of these two groups, the general practitioners were by far the larger, and by the 1830s general practitioners probably provided some ninety per cent of the qualified medical care in England. But the role of the general practitioner necessarily involved not only medicine and surgery but, in a period in which the birth rate had not yet begun to decline, a good deal of midwifery, and generally pharmacy too. Thus the development of the general practitioner was a process which necessarily undermined the tripartite structure since the development of general practice involved a breaking down of the barriers separating what the Royal Colleges saw as distinct areas of practice, some of which they considered to be of much higher status than others. The Royal Colleges, dominated by the consultants, bitterly resisted this development, however, for they feared that the incorporation of what they regarded as manual and trading elements into the doctor's role threatened the high status which physicians had long enjoyed,
and which surgeons had recently attained. Thus the attempt on the part of the Royal Colleges to maintain the traditional tripartite structure was simultaneously an attempt to stem the rise of the general practitioner: a policy which not surprisingly gave rise not only to a good deal of resentment amongst a large section of the profession, but also to a very long and very bitter campaign for medical reform on the part of the general practitioners.

The effect of the policies of the Royal Colleges was, of course, to deny general practitioners any participation in the decision-making processes within the two most prestigious medical corporations; general practitioners were thus effectively excluded from the major institutions of professional power. As one practitioner put it, the great majority of the profession was 'excluded from all power and influence in the corporations; the Colleges and Companies being closed in their face; and they having not the slightest chance of attaining places in the Council of the College of Surgeons'. Thus while the consulting surgeon — who held a qualification in surgery only — was eligible for election to the Council of the College of Surgeons, the general practitioner — who frequently held, in addition to his surgical diploma, a qualification in medicine from the Society of Apothecaries — was excluded. Commenting on this situation, the Lancet held that the Royal Colleges have discovered the most extraordinary ground for creating professional distinction that ever entered into the mind of man. With them the chief qualification for eminence in the healing art is ignorance of one or the other half of it. A physician need not know much of physic; an entire ignorance of surgery will be sufficient to give him a respectable standing; a surgeon need not possess any real knowledge of surgery, but if he be sufficiently ignorant of physic — if he do not know the gout from the measles — that will render him 'pure', and make him eligible to receive the highest appointments; but a 'general practitioner' — a man who is so preposterous as to understand both physic and surgery — is fit only to become a subordinate.
In addition to the Royal Colleges there was, of course, the Society of Apothecaries. Few general practitioners, however, looked to the Society to represent their interests; for not only had the Society retained a constitution more typical of a city trading company than of a professional organisation, but it also had a long association with the apothecary as the inferior member of the medical profession and as recently as 1815 had been a party to the Apothecaries' Act, which defined more clearly than ever the inferior status of the apothecary. As James Bird explained in 1848, many rank-and-file members of the profession preferred the title 'general practitioner' to the more traditional one of 'surgeon-apothecary', since the term 'apothecary' 'was intended to denote an inferior grade'. The long association with 'Rhubarb Hall', as the Lancet called it, was more a hindrance than a help to the general practitioners in their fight for professional advancement.

In the first half of the nineteenth century, there was thus no medical corporation to represent the interests of general practitioners. As James Bird pointed out, 'neither the College of Surgeons nor the College of Physicians has any sympathy with the general practitioners; the interests of that body have at all times been placed in abeyance, and for want of a recognised position they have hitherto been disregarded in all communications with the Government.' He added that 'whenever any medical question, or any question affecting the public health, is brought before the Legislature, there is no body, no head, to represent the interests of nine-tenths of the profession.' The same point was made by a correspondent of the Lancet, who pointed out that general practitioners 'have no colleges at which to confer; nor have they any other means by which, as a body, to make known their wants, to protect their rights, or to redress their grievances'. He went on to note that general practitioners had not even been represented amongst those bodies which gave evidence to the 1834 Parliamentary Select Committee on Medical Education: 'the colleges of physicians and surgeons have been there represented; the members of both have given their evidence; whilst the most numerous body of the profession (without a head) have silently looked on.'
situation of general practitioners within the profession, as well as the increasing anger and frustration felt by many general practitioners, was perhaps most clearly pointed out by the *Lancet* when it asked, 'where have the surgeons in general practice their headquarters? What body presides over their interests? Alas! they have no local habitation, and no presiding body. Positively, the only set of men who have a right to be considered as forming the medical profession in this country have neither representatives nor protection.'

In addition to excluding the general practitioners from their governing Councils, both Royal Colleges persistently refused to make provision for the type of education required for general practice. Thus the general practitioner required an education and examination in medicine, surgery, midwifery and pharmacy, but no medical corporation would agree to provide or examine an integrated syllabus embracing all branches of practice. As we have seen, the College of Surgeons consistently refused to make provision for the medical as well as the surgical education of the general practitioner, preferring to confine its interest to pure surgery, while the College of Physicians similarly refused to alter its traditional policy of examining in physic only. Thus the general practitioner was compelled to go to the Society of Apothecaries for his examination in medicine and pharmacy, and to the College of Surgeons for a separate examination in surgery. Moreover, for the first quarter of the nineteenth century, neither the Royal Colleges nor the Society of Apothecaries would have anything to do with the practice of midwifery. From 1827, the Apothecaries' Society required candidates for its diploma to provide evidence that they had received training in midwifery, but the Royal Colleges continued to maintain their traditional examinations in physic and surgery only. Educationally, politically and socially, the general practitioner was rejected.

Given this situation, it is hardly surprising that consultants and general practitioners should have viewed the tripartite institutional structure of the profession in radically divergent ways. Although the nineteenth century consulting practitioner no longer corresponded in all respects to the traditional 'pure' physician or surgeon, there were, nevertheless, a num-
ber of similarities between the consultants and the pure physicians and surgeons which meant that consultants, unlike general practitioners, could be assimilated into the traditional professional structure without any great difficulty. Consultants normally held a qualification in either medicine or surgery, but rarely both; they could thus continue to designate themselves as physicians or surgeons, to enjoy the legally defined privileges of those groups and, indeed, to maintain the fiction that medicine and surgery were quite separate branches of practice which were best left to separate groups of practitioners. Moreover, like the pure physician and surgeon, consultants rarely practised pharmacy or midwifery; hence they were not excluded from the Councils of the Royal Colleges and indeed the consultants effectively monopolised membership of these Councils throughout the first half of the nineteenth century. Moreover, if consultants could easily be assimilated into the traditional institutional structure of the profession, there was also no reason why they should desire to change it. Not only did the hierarchical tripartite structure legally confirm their superior status over the general practitioners, but within this structure the consultants continued to enjoy a disproportionate share of the financial, social and political rewards within the profession. In short, a radical change in the institutional structure of the profession offered little prospect to the consultants of improving their already favourable situation, whilst there was every possibility that such a change might involve a radical change in the balance of power within the profession, and that general practitioners might benefit at the expense of consultants.

The situation of general practitioners, on the other hand, was quite different. As we have seen, general practitioners were a new group, who had developed in the late eighteenth and early nineteenth centuries alongside a much older professional structure. The general practitioner was not a physician, a surgeon, nor an apothecary. Nor was his situation within the medical profession adequately conveyed by the term surgeon-apothecary, in spite of the fact that by the middle of the nineteenth century most general practitioners held a double qualification from the College of
Surgeons and from the Society of Apothecaries. For the title of surgeon-apothecary implies that the role of the general practitioner could be defined in terms of the traditional categories within the profession; this, however, is quite wrong, for in combining the roles of surgeon and apothecary a quite new type of practitioner had emerged. As one observer put it, general practitioners were 'a new class ... different from any hitherto known, formed by a combination of the three already in existence, but having no exact resemblance to any of them'.

For this reason, it is suggested that the term general practitioner was more accurate than surgeon-apothecary; the new terminology reflected the emergence of a new role, one that could not be fitted into the traditional professional structure. While there was a place within the traditional structure for the surgeon and for the apothecary, there was no place for the practitioner who combined both roles. The position of general practitioners, as Peterson has noted, was anomalous; they were a 'hybrid class ... relegated to inferior positions within the corporations and neglected by their leadership'.

A correspondent of the *Lancet*, writing on behalf of the general practitioners, summed the situation up in the following manner. General practitioners, he said,

form the principal body of medical practitioners, and yet, strange to say, we are the outcasts of every medical corporation. The College of Physicians spurn us; no merit, however exalted, could ever qualify one of our body for admission to the sanctum sanctorum of Pall Mall East. The College of Surgeons, although it accepts our guineas, and permits us to be called 'Members', excludes us from ever having a voice in its proceedings. Even the Worshipful Company of Apothecaries turn up their noses at us. But is this as it ought to be? Assuredly not; and it only remains for ourselves, calmly and deliberately, but firmly and in unison, to bring the matter forward, and the system must be altered.

The structure of the medical profession involved a basic contradiction. On the one hand, the institutional framework of the profession continued to be organised around a rigid
separation of the roles of the physician, the surgeon and the apothecary. On the other hand, in practice these traditional divisions were rapidly breaking down as a new professional structure emerged in response to changes in the wider network of relationships in which practitioners were involved: hence the contradiction between a newly emerging professional structure and traditional professional institutions organised on quite different principles. It was this structural tension within the medical profession which gave rise to a movement for medical reform amongst general practitioners, for since the general practitioner corresponded to none of the traditional types of practitioner, there was no place for him within the traditional institutional structure. Unwanted by all the medical corporations, the general practitioner was at best tolerated, never welcomed as a full member of the professional community.

For much of the first half of the nineteenth century — and in particular, from the mid 1820s — the relationship between the general practitioners and the consultants who controlled the Royal Colleges was more or less openly hostile, as the general practitioners began a long struggle for medical reform aimed at achieving recognition of what they held to be their rightful place within the profession. Amongst other things, they put forward demands for the democratic reform of the medical corporations, for the reform of medical education and licensing, and for the abolition of the tripartite structure based on the differentiation between physicians, surgeons and apothecaries. This latter point was of major importance, for it was only by breaking down the traditional separation between the different branches of practice, and by developing institutions which more adequately represented their interests, that general practitioners could hope to achieve recognition of general practice as a legitimate and honourable form of medical activity.

Inevitably, one consequence of the development of this reform movement within the profession was the polarisation of general practitioners and consultants into opposite camps; for, as we have seen, the consultants had a strong vested interest in maintaining the established institutional structure of the profession. Moreover, the fact that the consultants
monopolised the key political offices within the most powerful institutions within the profession enabled them to block, for very many years, the general practitioners' demands for reform. The result was that the struggle for reform was very lengthy, frequently very bitter, and even violent on occasions. Some of the major aspects of this reform movement will be examined in the next three chapters.
PART II

The Campaign for Medical Reform
BY THE 1820s, the major line of division within the profession was becoming increasingly sharply drawn, and it is hardly an exaggeration to say that from then until the passing of the Medical Act in 1858 the medical profession was characterised by more or less permanent conflict as the general practitioners and the Royal Colleges engaged in a protracted and sometimes bitter struggle.

The general practitioners' campaign for reform was not only very long but also very complex; for although many of the general practitioners' demands for reform were closely interrelated, slightly different issues tended to come to the fore at different times. Moreover, the general practitioners' movement was anything but monolithic for, especially during the 1830s and 1840s, a multiplicity of medical reform associations was founded, some of which had only a very brief existence; whilst the leadership of the general practitioners' movement tended to pass rapidly from one organisation to another. The picture is further complicated by the fact that, although the general practitioners were generally united in their opposition to the policies of the Royal Colleges, they were on occasions deeply divided amongst themselves as to the precise nature of the reforms which they wished to bring about. Finally, the situation in relation to the medical reform movement within Parliament also became very confused at times, for between 1840 and 1858 there were no less than seventeen different medical reform Bills introduced into the House of Commons and, on one occasion, there were three separate Bills before the House at the same time.

In view of both the length and the complexity of the general practitioners' campaign for reform, the present work
does not claim to offer a comprehensive analysis of the development of the medical reform movement; rather, we must be content simply to concentrate on some of the major aspects of this development. This will, however, serve to indicate something of the multi-faceted character of the general practitioners' campaign, as well as giving some indication of the intensity of the conflict, and even the bitterness which sometimes characterised relationships in what was (especially in the 1830s and 1840s) a deeply divided profession. This examination of some of the major aspects of the reform movement will also be useful in illustrating the degree to which the Royal Colleges set themselves firmly — and with considerable success — against any reforms which threatened the basic institutional structure of the profession and their dominant position within it. Later in the book, we will examine in some detail what is generally seen as the culmination of the efforts of the medical reformers, namely the 1858 Medical Act.

A major part in the general practitioners' campaign for reform was taken by the Lancet, which was founded in 1823 by Thomas Wakley who, in addition to being a member of the College of Surgeons, subsequently became the radical Member of Parliament for Finsbury. From the beginning, the Lancet unambiguously identified itself not with the hospital physicians and surgeons, but with the rank and file members of the profession; and the new journal ceaselessly complained of what it, together with a growing section of the profession, regarded as the abuses and the undemocratic practices within the Royal Colleges. Moreover, the Lancet quickly established for itself a large readership amongst members of the profession. Wakley's biographer estimates that by 1825, the Lancet had a regular circulation of upwards of four thousand,¹ which probably made it the most widely read medical journal of the period. From 1823, therefore, the general practitioners had an important ally amongst the national medical press.

Two or three years after the Lancet began publication, the struggle for reform began in earnest. The immediate target for the reformers was the Royal College of Surgeons, and the struggle within the College was particularly intense during the
period from 1826 to 1831. This particular campaign is of some interest, not least because it raised an issue which, to some extent, proved to be a source of division amongst the reformers themselves, at least until the 1840s. This issue related to whether the members of the College of Surgeons — the ‘surgeons in general practice’, as the *Lancet* called them — should seek to democratise the structure of the College of Surgeons and to extend their rights as members within the College, or whether, instead, they should seek to make common cause with other general practitioners, including those who were not members of the College of Surgeons, in establishing a new institution which would more adequately represent their interests. In the years 1826-7, the reformers sought to claim what they felt to be their rights as members of the College; in 1831, however, the experience of five years of unsuccessful struggle had given rise to the first plan for what would have been, in effect, a separate college of general practitioners.

The immediate cause of discontent within the College of Surgeons was the new regulation relating to surgical education issued by the Court of Examiners of the College in 1824. In 1822 the Court of Examiners had issued a regulation which stated that the College would only recognise those courses on anatomy which had been delivered in the winter session, and this was followed, two years later, by a second regulation which severely restricted the number of hospitals which the College would recognise for teaching purposes. The *Lancet* immediately responded to the new regulation by pointing out that most members of the Court of Examiners were themselves teachers at the large London hospitals, and it accused them of passing the regulation purely out of self-interest.² Certainly it is clear that both regulations had the effect of restricting competition from other teachers, the former by withdrawing recognition from the courses given by the private schools, and the latter by compelling many students in the provinces to come to the London hospitals for their professional education. Shortly afterwards, further criticism of the regulation came in the form of a pamphlet by Dr. John Armstrong, a lecturer at the Grainger Brothers’ Webb Street School, in which he drew attention to the
'injurious conduct, and defective state' of the College, and in which he pointed to the damaging consequences of the new regulation for some of the excellent private schools.  

Criticism of the College was not long confined to criticism of the new regulations, for many practitioners saw the new regulations as simply one more symptom of the unrepresentative constitution of the College, a constitution which centralised all decision-making powers within the College in the hands of a small self-appointed group of hospital surgeons. Consequently the attack on the College broadened. In 1825-26, the *Lancet* published a series of letters from James Wardrop, under the pen name ‘Brutus’, attacking not merely the new regulations but the whole structure of the College. On February 18, 1826, a protest meeting of members of the College was held at the Freemasons’ Tavern.  

As Sprigge has noted, this was an important development, for it represented the first organised step taken by the members against the College Council. At the meeting, resolutions were passed criticising the new regulations, the examinations of the College, the mismanagement of the museum and library, and complaining of the fact that the members were required to enter and leave the College by the back-door entrance, the front door being reserved for Council members. Most importantly, however, the members passed a resolution which demanded a fundamental change in the structure of the College. It was agreed that a petition be ‘immediately prepared and presented to the House of Commons, praying for the appointment of a Committee to inquire into the abuses of the said College, with a view to ultimately obtaining from His Majesty a New Charter, which shall provide that the officers of the College be annually chosen by the members, so that EACH MEMBER may have a voice in the election of those persons who are to regulate the proceedings of that College.’  

The members of the College re-assembled on 4 March 1826 to receive a report from the petition committee appointed at the previous meeting. The committee had approached the Council of the College asking them to join in the application to Parliament; the Council, however, had ‘contemptuously refused’, and on 26 April 1826 the Council of the College
issued a long statement replying to the members’ demands. The Council denied that the constitution of the College was the cause of the ‘alleged injuries and grievances’, and it went on to argue that the ‘evident object of this representation is the subversion of the present government of the College, and the substitution of elections to offices of control and responsibility, by members, who for the most part exercise the professions of apothecaries and accoucheurs. There can be little doubt, that in the event of such an innovation, the Institution would soon cease to be a College of Surgeons or of Surgery.’ It is clear from this statement that the Council recognised that by this time most members of the College were, in effect, general practitioners, and that any constitutional change along the lines demanded would open the way to control of the College by surgeons in general practice, with a consequent shift away from the College’s traditional policy of emphasising the practice of pure surgery. The Council saw itself as, in effect, the last bulwark against the ‘degradation’ of the College into a college of surgeon-apothecaries or general practitioners.

The petition to the House of Commons for the abrogation of the Charter of the College was drawn up in 1826 and, early in 1827, preparations were made to present the petition to Parliament. It was at this stage that the College was to use its considerable influence to undermine the movement for reform. Edwin Lankester, who was a prominent figure in the early history of the British Medical Association, was later to refer to the influence which the Royal Colleges were able to exert through both formal and informal channels, and the difficulty of implementing any plan for reform to which they were opposed. ‘Few persons, unless they have lived in London, could form any idea of the power of the ruling body of these Colleges, not so much in their corporate capacity, as in that of individuals. They were the medical attendants of nearly every member of both Houses of Parliament, and they were frequently consulted by these members with regard to particular bills which came before them.’ The campaign of 1826-7 provides a clear illustration of the problem to which Lankester referred.

In March 1827, the members of the College approached
Robert Peel to ask him to present their petition. As Home Secretary, Peel would have been an important ally had the members been able to persuade him to support their cause. Peel, however, was a personal friend of John Abernethy, president of the College in 1826, and of Sir Astley Cooper, president in 1827; not surprisingly, he declined to present the petition. The petition was ultimately presented to Parliament by Henry Warburton, MP for Bridport, on 20 June. By the time Warburton presented the petition, Peel, together with a number of other MPs, had been well briefed by the College. Warburton’s fellow MP, Joseph Hume, recalled in 1831 that Warburton had been anxious to introduce into the House a motion founded on the members’ petition; however, Warburton ‘found the influence in the house so great against it, that so many hon-members had been sent to upon it, consulted upon it, and had been so much prejudiced and influenced against it, that Mr Warburton, after consulting with me, abandoned the attempt to bring forward a motion founded upon that petition, for the appointment of a committee to inquire into the abuses of the college. He felt that it would be better (and I advised him to the same course) to let it drop than bring forward a motion which was sure to fail.’

Warburton accordingly proposed a much more modest motion. In his speech to the House, he listed the members’ grievances, including the fact that the College Council considered that those who practised as surgeon-apothecaries and those who practised midwifery ‘were less qualified than others for the honours and advantages of that institution’. He then moved a relatively uncontroversial motion, which simply required the College to provide the House with certain information. In particular, the motion called for a return from the College of all public money lent or granted to the College from 1799, and an account of all monies received by the College from its members in 1825 and 1826. Warburton’s motion also required the College to supply information concerning the regulations under which members and students were admitted to the museum and library and a statement of the number of persons examined by the College since 1800. Peel defended the College, saying that the actions
of its Council had met with the approval of a number of eminent surgeons, and that he had found the Council 'very willing to remove every evil of which the petition complained'. He did not, however, oppose Warburton's modest request for information, to which the House agreed.

Following this debate in Parliament, the Council made two minor concessions: the library was finally opened for the use of members and the back-door entrance was abolished, apparently on the suggestion of Peel — only to be replaced by a new side entrance for members, who were still forbidden to use the front door in Lincoln's Inn Fields. These were, however, the only concessions. Warburton had been unable to raise the fundamental issue — the constitution of the College — and the Council was determined that the constitution would remain unchanged. The College duly supplied the returns required by the House of Commons, but no member apparently felt sufficiently interested or well-informed to carry the matter further, especially in the light of the support which the College had been able to organise in its defence. The returns were simply laid upon the table of the House and no debate ensued. Apart from a little publicity for their cause, the members had gained virtually nothing.

For the next three or four years, relations between the Council and the members of the College remained strained. The Lancet continued to condemn almost weekly the conduct of the Council; in January 1831, it raised the possibility of establishing a new college which would represent not merely the surgeons in general practice, but all general practitioners, whether or not they were members of the College of Surgeons. The Lancet argued that 'However much the timid may dread the word, we hesitate not to say, that in our profession a revolution is much wanted — a complete breaking up of the restrictions and monopolies by which the members of the different colleges have been plundered of their rights . . . The members of the profession should duly investigate such facts as these, when they will soon be taught that evils of such vast magnitude can only be effectually, radically, removed by the establishment of a NEW MEDICAL COLLEGE.' This plan for a new college, elaborated in the
course of a particularly bitter dispute within the College of Surgeons in 1831, was to be the first of a number of plans to establish a college which would represent all general practitioners and would, therefore, cut across the traditional institutional affiliations to one or other of the medical corporations.

The incident which sparked off the new conflict within the College of Surgeons in 1831 was a relatively trivial one, but within a context of mutual suspicion and hostility much broader issues were soon to be raised. On 5 February 1831, the *Lancet* reported that a circular had been sent to surgeons serving in His Majesty's Navy, to the effect that they were not to attend the King's levees. The circular was, said the *Lancet*, 'a deliberate, cold-blooded insult' to naval surgeons, and the following week it called on members of the College to assemble at the College on the occasion of the Hunterian Ovation in order to discuss the matter. This call to the members was, in effect, an assertion that the members and not the Council had a right to decide on the business of the day; as the *Lancet* put it, the theatre 'belongs to the MEMBERS, and surely they could not employ it for a better purpose than in making an attempt to rescue from insult a most important branch of the profession'. On the appointed day, the members assembled in the lecture theatre, which was 'crowded to excess', and prior to the Hunterian Oration two resolutions were passed, one of which requested the president and Council to memorialise the Lords of the Admiralty with a view to having the offending circular withdrawn. After the oration, the acting-president, Robert Keate, met the members and agreed to lay the members' request before the Council.

The members' resolution was presented to the Council at its meeting on 22 February, when it was resolved 'that such documents cannot be received on account of the irregularity of the proceedings'. The *Lancet* responded by saying that 'the members, doubtless, gave offence to the worthy and liberal-minded Council, because they presumed to disturb the awful silence, which has so many years prevailed within the walls of the College, by discussing a professional grievance *in their own theatre*.' It called on the members to 'assert their rights in a place where they never ought to have remained
dormant' and to demonstrate that they were 'no longer the miserable tools of a despicable, dark-minded oligarchy'. Finally, the *Lancet* suggested that the members should meet again in the theatre of the College on the following Tuesday. A lecture was due to commence at 4 pm; the doors were to be opened at 3 pm, and the meeting should commence as soon after 3 pm as possible. Once again it claimed that the theatre belonged to the members, and that they therefore had the right to decide the purposes for which it was to be used: 'Let us prove that we are not to be checked; that we are not to be defeated in our efforts, by this miserable, self-conceited, self-perpetuating oligarchy; but let us meet like men of rank and character, and of education and of knowledge, in *our own theatre*, and there discuss in the presence of our charter-protected tyrants, those measures which we may deem best calculated to uphold the honour, and maintain inviolable the rights and privileges, of our profession.'

On Tuesday 8 March, the day of the lecture, the Council placed an advertisement in *The Times* and other morning papers, to the effect that the door of the College would not be opened until shortly before the start of the lecture. The Council also stated that 'the theatre is opened for the sole purpose of the lectures', and gave notice of their determination 'henceforth to prevent discussions on any subject from taking place in the theatre of the College'.

That afternoon, some three to four hundred members assembled at the College and occupied the theatre, thus preventing the lecture from taking place. When the president and Council entered, they tried without success to have Thomas Wakley, editor of the *Lancet*, removed by a Bow Street officer. Deciding that it was impossible to go ahead with the lecture, the Council finally withdrew amidst loud cheering. The members then went ahead with their own meeting, in the course of which it was pointed out that the issues involved had now become much broader than the one which had originally sparked off the dispute. As Wakley put it, 'when this subject — the exclusion of naval surgeons from attending his Majesty's levees — was brought before the attention of the College ... it stood as a detached subject —
one which was entirely unconnected with our rights as members of this College. Unfortunately from the very untoward circumstances, the question has now become involved with many others which seriously, most seriously affect our rights. Thus more fundamental questions had once again been raised concerning the structure of the College as a whole, a fact which was clearly recognised in a motion carried with only two votes against to the effect that the members regretted the refusal of the Council to act on the resolution presented to them, but added that this refusal is another added to the already innumerable existing proofs that the President and Council are alike indifferent to the honour, happiness, and respectability, of the commonalty of this chartered College.

Shortly after this resolution was passed, a number of Bow Street officers entered the theatre, with the instruction to eject Wakley. A number of members came to Wakley's assistance, but the editor of the Lancet was finally removed after a violent struggle in the course of which he received a blow with a truncheon. Although Wakley had been evicted, most members remained in the theatre, and it was unanimously resolved to send a deputation to the Lord Chamberlain to complain of the order relating to naval surgeons. The deputation duly waited on the Lord Chamberlain, and the offending order was withdrawn.

Four days after the violent meeting of 8 March, the Lancet published an 'Address to the medical profession of Great Britain and Ireland', in which it referred to the 'foul, unprovoked, and illegal assault' on the members of the College, which was committed 'by order of — we blush to say it — by order of their Council'. The address claimed 'thus have our rights been trampled upon, our lives endangered, our feelings outraged, and our profession insulted, by our own Council', and it went on to express the hope that 'no medical student will present himself for a diploma stained with the blood of his senior colleagues'.

In the same issue, there was an announcement which stated that 'in consequence of the atrocious assault committed upon the Members of the College of Surgeons', a public meeting of the profession was to be held at the Crown and Anchor
tavern in the Strand on 16 March. At this meeting, a plan would be introduced for the institution of a new medical college, 'founded upon the most enlarged principles, and in which all legally-qualified practitioners, whether physicians, surgeons, or apothecaries, will be associated upon equal terms, will enjoy equal rights, and will be recognised by the same title'. As we have noted, this represented an important change of strategy, for since 1826 the efforts of the reformers had been directed to bringing about changes within the College of Surgeons, rather than with instituting a new college.

The meeting on 16 March aroused considerable interest and was attended by thirteen hundred members of the profession. At this meeting, it was resolved that 'the establishment of a new medical college on principles in accordance with the progress of science, presents, at the same time, the most practicable means of obtaining a general and complete reform in the system of medical legislation, is calculated to afford the greatest security to the public health, and will most effectually increase the utility, and advance the rank and respectability, of the general body of the medical profession.' The wording of this resolution — that the new college should be established 'on principles in accordance with the progress of science' — is important, for many general practitioners claimed that the progress of medical science had effectively undermined any rationale for the tripartite separation between the different branches of practice, so long institutionalised in the structure of the Royal Colleges and the Society of Apothecaries. As the proposer and seconder of the motion pointed out, this tripartite separation was no longer acceptable to many members of the profession. Thomas King, who proposed the motion, argued that there was no natural distinction between medicine, surgery, and the dispensing of medicines, and he claimed that the 'divisions which at present distinguish the profession are in every respect detrimental to the welfare of our fellow-creatures and the advancement of science'. It was therefore imperative that the new college must embrace in its examination 'every department of medicine and surgery'.

A committee was appointed to draw up a plan for the
formation of the proposed London College of Medicine, as it was to be called, and from their report it is clear that one of the major objectives of the new college was to break down the tripartite structure of the profession. The new college was not to be a college of surgeons, or of physicians, or of apothecaries; it was to be, in effect, a college of general practitioners. Thus all persons legally qualified to practise in any branch of the profession were deemed eligible candidates, without examination, for the diploma of the College, and all those who possessed the diploma were to be denominated Fellows, and were to enjoy the title of Doctor. Thus would the new college 'cast aside the absurd distinctions which now exist in the profession, as to names, such as Physician, Apothecary, Surgeon, and Accoucheur'. The Lancet recognised that some physicians — the only group which, at that time, enjoyed the right to use the title 'Doctor' — would object to this scheme and would 'allege that it is "infamous" to confer upon the general practitioner the title of "Doctor"'. However, the Lancet argued there was no reason why general practitioners should not have this right, for the medical attainments of many general practitioners were 'immeasurably beyond those of hundreds of individuals who are now invested with that mark of distinction'.

Moreover, the college was to offer the first comprehensive examination designed to meet the needs of general practitioners. Thus all students who presented themselves for examination were to be examined in all branches of medical science — anatomy, physiology, pathology, surgery, materia medica, semeiology, and the 'practical application of those facts and principles in the practice of medicine, as empirically divided into medicine, surgery, and midwifery'. The Fellows were to be free to practise all branches of medicine, and even if candidates for the diploma wished to specialise in a single branch of practice, 'public security will demand that . . . [they] display a competent knowledge of the whole'. The public would then have the 'infinite satisfaction of knowing that every possessor of the diploma . . . has proved that he is well qualified to practise in every branch of medical science'.

The new college was to be organised on democratic principles, with the governing Senate being elected annually by
the whole body of Fellows. In addition — and in marked contrast to the regulations of the College of Surgeons — medical students were not to be required to produce certificates of attendance at any particular institution, but were to be free to acquire their medical education in whatever institution they chose to attend. The question of where candidates had received their medical education was deemed to be immaterial; the real question was to be whether the candidate had a sufficient knowledge of medicine to pass the examination of the college. Thus what the Lancet called the ‘plundering “certificate system”’ of the College of Surgeons was to be 'completely exploded' in this new institution. 

In short, the London College of Medicine was, as Sprigge has put it, 'to do everything as properly as the existing College did everything improperly'.

The proposed new college was clearly seen by some medical men not only as a solution to the problems facing general practitioners, but also as a development which presaged the final break-up of the existing medical institutions. Thus one practitioner from Rotherhithe, for example, in welcoming the plan to form the London College of Medicine, wrote 'Farewell to our monopolizing colleges and corporations! Rotten in constitution, what can uphold them? The very walls, which have so long concealed from public view their fraudulent and tyrannising machinations, are already shaken to their foundations . . . At this moment they totter, and the hour is fast approaching when they will assuredly fall. I cannot help, Sir, expressing myself thus strongly . . . because I have seen the general practitioner trampled to the ground by these vampires of the medical world.' Throughout the summer of 1831, the Lancet published a number of similar letters in support of the new college, and the journal reported frequently and optimistically on the progress and prospects of the new institution.

By the autumn, however, it was already becoming clear that all was not well with the new college, and that support for the new institution had not been as widespread or as sustained as the Lancet had originally hoped. On September 24, the journal announced that the committee of the College had decided to postpone the general convocation, due to be
held on 29 September35 and by October, the *Lancet* was already denying rumours that the London College of Medicine was foundering.36 In the months that followed, references to the London College became less and less frequent in the pages of the *Lancet*; from November 1831 to August 1832, the new college was referred to less than half-a-dozen times. Eventually, in October 1832, the *Lancet* published a letter from a correspondent in which the writer said that he, and other readers, 'cannot fail to regard with considerable apprehension and anxiety, the ominous silence your pages have latterly evinced respecting the condition of the affairs and the future prospects of the London College of Medicine — as, for instance, the state of its funds, the number of its enrolled members, the means designed, and the period when it is intended to apply to the legislature in order to render it a corporate body; and, above all, the circumstances affecting the probability or non-probability of its eventually becoming such.'37 The *Lancet* did not offer a reply. By this time, it was clear that there was insufficient support for the establishment of a new college. The plan to institute the London College of Medicine was quietly abandoned.

At first sight, the failure of the new college may seem surprising for, at least superficially, the new college would seem to have met all the requirements of the reformers, both in terms of providing a suitable education and licence for general practice, and in terms of giving general practitioners effective political control over their own affairs. Why, then, was there so little sustained support for the new college from members of the College of Surgeons, almost all of whom practised generally?

Unfortunately, the only original source of information relating to the London College of Medicine appears to be the *Lancet* for the period between March 1831 and October 1832, and that journal simply allowed the short-lived proposal for a new college to fade away without any comment and without giving any reason for its failure. Nevertheless, it is clear that the relative lack of support for the new college was closely associated with the development — or more precisely, with the relatively low level of development — of what may be called a 'general practitioner consciousness',
for during this early part of the reform movement, the
general practitioners continued to be divided amongst them­
selves, largely along corporate lines.

In this context, it is important to bear in mind that
although the London College of Medicine was to be open to
all legally qualified practitioners, the proposal for the new
college was born specifically out of a conflict within the
College of Surgeons, and there is little doubt that the new
college aimed to attract its initial support largely from
amongst the membership of the College of Surgeons. The
members of that College were, however, in a structurally
ambiguous situation, and this ambiguity was nicely captured
in the phrase which was frequently used by the Lancet to
refer to the members of the College of Surgeons: 'surgeons
in general practice'. Thus, on the one hand, they were mem­
bers of the College of Surgeons with a clear and legally
recognised affiliation with that institution, whilst on the
other hand, they were also general practitioners and as such
had certain common interests with other general practitioners
who were not members of the College of Surgeons. Thus the
members of the College of Surgeons were faced with a
dilemma: should they seek to reform the College, and to
extend what they saw as their rights as members of the
College; or should they, in effect, ignore their institutional
affiliation to the College, and instead make common cause
with other general practitioners — physicians, surgeons and
apothecaries — in a new institution?

This problem almost certainly did not arise in such an
acute form for those general practitioners who simply held
a licence from the Society of Apothecaries, for few — if any
— practitioners felt any real commitment to what had been,
and to some extent still was, a trading corporation; 'Rhubarb
Hall' was rarely seen as an institution worth preserving, even
if it could have been reformed. The Royal College of
Surgeons, however, was a different matter. Not only did the
College enjoy the prestige conferred by the grant of a Royal
Charter, but it also included amongst its members all the
leading surgeons in England, many of whom sat on its Court
of Examiners, a fact which gave the College's diploma a
status which was respected throughout the country. The
respect in which the College's diploma was held may be judged by the fact that evidence presented to the Select Committee on Medical Education in 1834 indicated that in the preceding five year period, more students had taken the examination for the diploma of the College of Surgeons than had taken the examination for the licence of the Society of Apothecaries, despite the fact that since 1816 the latter had been a legal requirement for all general practitioners, whereas the former was purely voluntary, the College having no power to require anyone to take its diploma and no power to prevent anyone from practising surgery without it. Candidates continued to present themselves for the College diploma, not because they were required to do so by law, but because of the status accorded to a diploma signed by many of the leading surgeons of the period.

It was largely because of the high status enjoyed by the College of Surgeons that most members were not prepared — at least at this stage of the reform movement — to cut themselves off from the College; indeed, it is probably true to say that in the early years of the reform movement (the 1820s and early 1830s) most 'surgeons in general practice' continued to identify themselves in the first instance as members of the College of Surgeons, and only secondarily as general practitioners. It was for this reason that most members were not yet prepared to abandon their attempt to reform the College and to gamble on the establishment of a new institution, whose status would have been uncertain. As Wakley's biographer has pointed out, the members wanted the College of Surgeons reformed, 'but they did not want it destroyed and a new institution with no history and no prestige substituted for it'. Despite the failure of this first attempt to establish a separate college, the plan to establish a college of general practitioners was to be revived in the 1840s by which time, as we shall see, it had come to command much more widespread support amongst general practitioners.

Throughout the early 1830s, the reform movement continued to be organised largely along corporate lines. Within the College of Surgeons, the members continued to criticise the unrepresentative character of the Council and to demand
reforms which would give the members effective control of their own College whilst, at the same time, quite separate attempts were being made by the licentiates to reform the structure of the Royal College of Physicians. From the middle of the 1830s, however, the nature of the campaign began to change as a growing number of practitioners became increasingly aware of the significance of the changes within the structure of the profession, and as more and more medical men began to conceptualise themselves specifically as general practitioners and to identify with others—whatever their corporate affiliation—who were similarly engaged in general practice. Medical men, in other words, were increasingly coming to define themselves not primarily as members of the College of Surgeons or as licentiates of the Society of Apothecaries but simply as general practitioners. One symptom of this growing awareness that general practitioners constituted a distinct group which cut across the traditional corporate lines was the emergence of associations of general practitioners committed to radical reform and formed with the explicit aim of uniting all general practitioners—whether physicians, surgeons or apothecaries—within a single organisation.

One of the earliest, and certainly one of the most radical, organisations to develop along these lines was the British Medical Association, which despite its title was primarily an association of general practitioners in the London area. This association, it should be noted, was a quite separate organisation from the association which is so well known within the profession today; the modern British Medical Association had its origins in a separate organisation of provincial practitioners formed in 1832 about which more will be said later.

From the beginning, the London-based British Medical Association set out to identify itself quite explicitly as a general practitioners' organisation; it was to be an association of 'the English general practitioners of medicine, constituting the great body of the profession', a body of practitioners whom, it was noted, had been facetiously termed the 'subordinates' of the profession. Moreover, the Association was established specifically with the idea of campaigning for radical measures of medical reform; literary and scientific
pursuits, which formed an important part of the activities of most medical associations, were specifically excluded from its statement of objectives.42

Within the Association, the relationship between the general practitioners and the medical corporations was immediately singled out as a major source of the general practitioners' grievances. The chairman of the new association, Dr George Webster, a general practitioner from Dulwich, said that 'had the constituted authorities, the colleges, the corporations, and the halls done their duty, we should not have been obliged to meet... to take the matter into our own hands, and form an association. But instead of protecting the profession, I fear they have frequently oppressed it."43 It was the medical corporations, he pointed out, which still strove to maintain those 'most unnatural divisions and degrading distinctions' which were institutionalised in what were usually called 'The Three Branches of the Profession', just as it was the medical corporations which had consistently denied general practitioners any participation 'in the smallest degree' in the management of their own affairs.44 The medical corporations demonstrated, in short, 'the natural and unfortunate effects of irresponsible power — the rottenness of the whole system of medical policy'.45

The major object of the association was to campaign for a radical change of the whole structure of the profession, involving the abolition of the tripartite structure, the unification of all branches of practice, and the establishment of a single controlling body which would be elected by the whole profession, and within which all practitioners would enjoy equal status: 'if what are now termed the three branches of the profession were comprehended in one general faculty of medicine, with the power of electing their own senators or council, we should soon have, as the legitimate and necessary consequence, a wonderful change in the aspect of medical affairs, and without this it is in vain to expect either unanimity, harmony or friendly feeling."46

In order to ensure that the new association would remain firmly under the control of general practitioners, it was decided that, although membership of the association was to be open to all qualified practitioners, the president of the
association should always be a general practitioner, whilst similarly only those who had been actively engaged in general practice should be eligible for membership of the controlling Council of the Association. In explaining the reason for this, the chairman pointed out that 'this is expressly to be a society of medical men who practise every branch of the profession, general practitioners. We commenced as such for we considered that the physicians already had their clubs; the surgeons had theirs; ... all these had their own exclusive associations ... this was to be a society of general practitioners, of the great body of the profession.'

Not surprisingly, the formation of the new association was unreservedly welcomed by the Lancet: 'The principles on which it is founded are identical with the interests of the general practitioner.' The rule which excluded hospital physicians and surgeons from holding any official position in the organisation was, said the Lancet, 'absolutely necessary, in order to obviate the complete subversion of those fundamental principles on which the Association must be established, if it be intended that it should be successful.'

General practitioners, it said, 'constitute, probably, full fifteen-sixteenths of the whole profession, and ought therefore, to take the lead in the management of their own affairs; and they must firmly retain the control of the Association in their own hands, or, we unhesitatingly predict, that they will be again and again betrayed.' Shortly afterwards, the Lancet reiterated this point, saying that the general practitioners of England and Wales have been taught ... by years of direful experience, that the mere university physician ... and the mere hospital surgeon, constituting the 'pures' of the 'highest ranks' in the profession, have combined with the heads of their own colleges in order to oppress, stigmatise, insult, and degrade those whom they have had the insolence to denominate the 'subordinate' members of the profession. Could it be expected, then, that the Provisional Council of the Association would be so utterly incapable of fulfilling the high trust which was committed to their charge, as to allow the enemies of general practitioners to exercise a
single function of the governing body in the new Association? Certainly not... The wrongs of general practitioners are to be redressed — the measures of relief are to be devised and enforced by general practitioners themselves... All the general practitioners in the kingdom will now have their minds fortified by the assurance, that their interests will not be sacrificed or betrayed.\(^5\)

In the next three or four years, medical reform associations began to develop all over the country, and the British Medical Association assumed the leadership role in trying to coordinate the efforts of the various regional associations by coopting their presidents and secretaries as members of the Council of the BMA.\(^5\) At the same time, the Association was also involved in working out in more detail its own plan for medical reform, in organising petitions to be sent to Parliament, and in sending delegations from the Association to see government ministers and other MPs believed to be sympathetic to the cause of medical reform.\(^5\)

The Association published its 'Outlines of a Plan of Medical Reform' in July 1839. The central proposal was one which aimed 'to unite all the legally qualified members of the medical profession... into “ONE FACULTY”, to be entitled “THE BRITISH FACULTY OF MEDICINE”'. The governing body of the Faculty was to be elected periodically by the whole membership, and all members were to receive the same title, to enjoy equal rights and privileges, and to have the right to practise in all branches of the profession. The Faculty was to be required to keep a register of all legally qualified practitioners, and only those who were so registered were to have the right to practise medicine.\(^5\)

Early in 1841, the BMA convened a conference of all the leading reform associations throughout the country in an attempt to get agreement on a reform bill which, it was hoped, could then be presented to Parliament. The Conference on Medical Reform, as it was called, was held at the Exeter Hall, London, and involved seventeen meetings between March and June 1841. In addition to the delegates from the BMA, delegates were also sent from associations of practitioners in Cornwall, Devon (South), Glasgow,
Gloucestershire, Nottingham and Taunton, from the Irish Medical Association, the East of Scotland Medical Association, the North of England Medical Association, and the Provincial Medical and Surgical Association. The last named association was later to play a very important part in the development of the medical profession, for after the London-based BMA had ceased to exist as a separate organisation when it joined with the National Association of General Practitioners in the mid-1840s, the Provincial Association changed its name in 1855 and, adopting the name formerly held by the London Association, finally emerged as the British Medical Association so well known today. It is, therefore, worth pausing briefly at this stage to say something about the early development of the Provincial Association, both because of its subsequent importance, and also because it played a controversial part in the Reform Conference of 1841.

Unlike the London Association, the Provincial Association had not been formed specifically to further the cause of medical reform, for its initial objectives were ‘friendly and scientific’ rather than medico-political and, in the first few years of its existence, the Association became involved only slowly and cautiously with the issue of medical reform. It was primarily for this reason that the Lancet, after initially welcoming the formation of the Provincial Association in 1832, became increasingly critical of its activities. Moreover, the Lancet quickly drew a link between the Association’s relatively slow involvement in the reform movement and the fact that the Council of the Association was dominated, in its early years, by physicians and surgeons attached to hospitals in the provinces. Many provincial hospital physicians and surgeons were, it should be noted, considerably more liberal than their London counterparts, who were much more closely associated with the conservative hierarchies of the Royal Colleges. Nevertheless, the Lancet was insistent that it was not in the best interests of general practitioners that they should be led by physicians and surgeons; in the Provincial Society, it said, the physicians have ‘in the very infancy of the society, obtained, apparently, the entire control of the association. We do not charge them with
having usurped any authority. They may exercise their function, legitimately, and without even the breach of professional etiquette; but still we resolutely say, that it is not for the interest of general practitioners that they should be placed under the guidance of physicians, however estimable they may be in the relations of private life, however exalted they may be in professional reputation.\textsuperscript{56}

The Provincial Association did, however, slowly become more involved in the reform movement. In October 1839, the Council of the BMA formally welcomed 'the accession of the Provincial Medical and Surgical Association to the ranks of reform, and the establishment, in consequence, of a correspondence and co-operation between it and this Association'.\textsuperscript{57} At its annual conference in the following year, the Provincial Association passed a resolution to the effect that 'steps should be taken to obtain medical reform on the principles of a uniform test of qualification and a representative system of government'.\textsuperscript{58} However, although the Provincial Association had, by 1840, committed itself to the cause of medical reform, its position was considerably less radical than that of the BMA, and these divisions became particularly evident in the course of the London Conference on Reform in 1841.

The plan of reform which had been drawn up by the BMA formed the basis for discussion at the conference, and it quickly became clear that the delegates from the Provincial Association had important reservations about parts of that plan. It was argued by some of the Provincial Association's delegates, for example, that whilst the representative principle was desirable, they did not regard it as an essential feature of any reform. The Chairman of the BMA immediately accused the Provincial delegates of 'retrograding' on the decision taken at their annual conference, with the implication that they did not properly represent the interests of the general practitioners who formed the bulk of the membership of the Association.\textsuperscript{59} More importantly, however, there was a fundamental disagreement over the extent to which the existing corporations should be respected in any plan of reform. The plan drawn up by the BMA would have effectively destroyed the Royal Colleges and the Society of
Apothecaries, for it would have taken away their major function — that of licensing practitioners — which would have become the responsibility of the new Faculty of Medicine; the vice-president of the College of Surgeons said that the plan of the BMA, if implemented, ‘would operate as a dose of arsenic to the college’. The delegates from the Provincial Association, on the other hand, insisted that ‘existing medical institutions be respected, provided their existence can be rendered compatible with uniformity of qualification, equality of privileges to practise medicine, and a fair system of representative government’. Throughout the whole proceedings, the Provincial Association delegates displayed a much more conciliatory attitude towards the Royal Colleges. As it became clear that a majority of those present were prepared to support the plan drawn up by the BMA, one by one the delegates from the Provincial Association resigned from the Conference. Although the reform movement had, by 1840, begun to break down the divisions along corporate lines within its own ranks, the Conference indicated that the reformers were still seriously divided, albeit along rather different lines.

Despite the failure of the Conference to reach agreement on a specific series of proposals, the issue of medical reform had, by this time, become firmly established on the political agenda. At a meeting of the BMA held in 1840, it was stated that in the previous session of Parliament, no less than 173 petitions containing the signatures of over 5,000 medical men — about a third of the entire profession — had been presented in favour of medical reform and, from 1840 onwards, the House of Commons became an increasingly important focus for the activities of medical reformers. In August 1840, the first Medical Reform Bill was introduced into the Commons, and this was followed, early in 1841, by two further Bills. From this time onwards, the issue of medical reform was to be a frequent subject of Parliamentary debate, with the appointment of a Select Committee to investigate the whole question in 1847, and with the further introduction of no less than fourteen Reform Bills before the final passage of the 1858 Medical Act.

Quite clearly, it is not possible — nor necessary — to exam-
ine each of these Bills in detail. It will, however, be useful to look briefly at a few of these Reform Bills, for some Bills had important consequences for the development of the general practitioners' campaign, whilst others defined in a particularly clear way the major issues involved. In the next chapter, therefore, we will examine the Bills introduced by Sir James Graham in 1844-5 and the Bill introduced by Thomas Wakley in 1847; and in the following chapter we will examine in some detail the passage of the 1858 Act itself.
AS WE noted in the previous chapter, three medical reform Bills were introduced into the House of Commons in 1840-41. All of these Bills were private members' Bills, but by the early 1840s, the government itself was becoming increasingly concerned to regulate the medical profession more effectively, partly because of the growing employment of medical practitioners as Medical Officers under the new Poor Law. From the middle of the 1830s, both the London-based British Medical Association and the Provincial Medical and Surgical Association had been in frequent contact with the Poor Law Commissioners, and both Associations had consistently urged the necessity of amending those provisions of the 1834 Poor Law Amendment Act which related to the provision of Poor Law medical services. In 1842, in response to a Parliamentary question on this issue, the Home Secretary, Sir James Graham, said it was not his intention simply to amend the law as it related to the Poor Law medical services, but also either in that session of Parliament or the following to introduce a much more general alteration in the laws regulating ‘the whole system of medical practice throughout the kingdom’.

Graham’s Bill was finally introduced into the House of Commons on 7 August 1844. It was not Graham’s intention that this particular Bill should become law for it was introduced towards the very end of the Parliamentary session in order to ‘allay the fears of the profession’ and to lay before the profession a concrete series of proposals for discussion. While Graham’s Bill did little to meet the demands of the general practitioners, the discussion which it provoked did give rise to a new organisation of general practitioners which,
for the next four or five years, was to push the reform move­
ment in a new direction.

Graham's Bill 'for the better Regulation of Medical Practice
throughout the United Kingdom' provided for the establish­
ment of a Council of Health and Medical Education which
would, amongst other things, have the duty of maintaining
a register of all qualified practitioners. The Council was to
have as its president a principal Secretary of State and the
remaining membership was to consist of five university
professors of medicine or surgery together with six represen­
tatives from the Royal Colleges in England, Scotland and
Ireland, and six other persons nominated by the crown; no
provision was made for general practitioners to be represented
on the Council. Moreover, the register of practitioners was
to have three divisions: physicians and surgeons were to con­
tinue to be recognised as distinct 'orders' within the profession,
with general practitioners being recognised as a third — and
clearly subordinate — class with the rather cumbersome title
of Licentiates in Medicine and Surgery.

Within Parliament, Graham's proposals were savagely
attacked by Thomas Wakley who, in addition to editing the
Lancet, had also been the MP for Finsbury since 1835. Wakley
said that petitions had been presented 'from all parts of the
Kingdom on the subject of medical legislation, and
what were the prayers of those petitions? Those prayers were
invariably that the petitioners might be invested with a con­
trolling power with reference to those Medical
Institutions to which they belonged. . . . How were these petitions
answered? Were the petitioners to acquire additional power
by the proposition of the right hon. Baronet? Were they to
elect the Council [of Health]? No; but they were to be
subject to a Council appointed by the Government, and by
Colleges of the conduct of which they had been complaining.'
In an apparent reference to Sir Benjamin Brodie, president of
the Royal College of Surgeons who had acted as an adviser
to Graham, Wakley said that the Home Secretary had been
'earwigged, deceived, misinformed, and had had the subject
misrepresented to him by somebody who had gained access
to him, while the medical body had not been able to obtain a
hearing'.
Outside Parliament, the reaction of general practitioners was equally hostile; and towards the end of 1844 the first steps were taken to form a National Association of General Practitioners in Medicine, Surgery and Midwifery, with the object of suspending any further consideration of Graham's Bill until the general practitioners had been 'legally recognised and placed in an independent position' — by which the National Association meant that it wished to see general practitioners incorporated in their own college. The London-based British Medical Association merged with the National Association, and within three months the new Association claimed a national membership of over 4000 general practitioners. A meeting of the National Association held in London in March 1845 attracted no fewer than 1000 general practitioners, who adopted 'almost unanimously' the Association's plan for the establishment of a separate College of General Practitioners in Medicine, Surgery and Midwifery.

In his evidence before a Select Committee in 1848, James Bird, a prominent member of the National Association, explained why they had objected to Graham's Bill and had decided to campaign for a separate College of General Practitioners. Under Graham's Bill, general practitioners, or Licentiates in Medicine and Surgery as they were to be called, were to be examined in medicine by the Royal College of Physicians, assisted by the examiners of the Society of Apothecaries, and in surgery by the Royal College of Surgeons. Graham's Bill thus proposed to place 'the power of licensing and of framing the curriculum of study, and of testing, by examination, all future persons engaged in general practice, under the control of the College of Physicians and Surgeons'. The National Association objected to this proposal, however, for, as Bird pointed out, 'neither the College of Surgeons nor the College of Physicians has any sympathy with the general practitioners'. It was felt that, under Graham's proposals, the Royal Colleges would give the general practitioners 'no more qualification than they thought proper' whilst there was, within the Royal Colleges 'a disposition to keep them in an inferior position'. As we have already seen, general practitioners were excluded from any participation in the affairs of the Royal Colleges whilst, in addition, Graham's Bill made
no provision for general practitioners to be represented on the Council of Health. General practitioners would thus continue to be left without any form of political representation within the profession; as Bird put it, there was 'no ostensible body to represent the interests of the mass of the profession'. It was largely on these grounds, he said, that the National Association had decided that there would be 'great advantage in the establishment of a new institution, that shall comprise within its fold, as it were, all those gentlemen who are engaged in general practice throughout the country ... on the condition that the College shall have the unfettered right and privilege of framing its own curriculum, and testing by examination all future candidates for general practice, not in medicine alone, not in surgery alone, not in midwifery alone, or pharmacy alone, but in all those branches that are essential to constitute an efficient general practitioner'.

As we have noted, Sir James Graham's original Bill of August 1844 had never been intended to pass into law, but simply to stimulate discussion. However, in February 1845, shortly before the mass meeting at which the National Association adopted its plan for a separate College of General Practitioners, Graham introduced a slightly revised version of his earlier Bill. The registration clauses and the composition of the Council of Health were unchanged, but the new Bill did propose that the Council should institute an examination in midwifery, although this examination was apparently to be voluntary rather than compulsory. In addition, the Bill included a new clause to the effect that all Licentiates in Medicine and Surgery should be members of the appropriate Royal College of Surgeons in England, Scotland or Ireland.

This new clause was important, for it indicated that the government was still hoping for some reconciliation between the general practitioners and the College of Surgeons which would obviate the necessity for the separate incorporation of general practitioners; in his speech to the Commons, Graham said that he would 'most deeply regret the separation of the general practitioners from the College of Surgeons'. Following the introduction of a new Charter which had been granted to the College of Surgeons in 1843, Graham hoped
'that the general practitioners and the College of Surgeons will be in a more close and honourable connexion than at any antecedent period'. He was, he said, 'most anxious to sustain the station, the honour, and the attainments of general practitioners' and he doubted 'whether we should be doing good, and should advance the honour and the character of the general practitioners, by dissolving the connexion between them and the College of Surgeons.'

The National Association immediately sent a deputation to see the Home Secretary, who asked for an assurance that the Association really represented the views of most general practitioners, and that there was no possibility of a reconciliation between the general practitioners and the College of Surgeons. The National Association was apparently able to persuade the Home Secretary on both counts. In relation to the latter issue, it was pointed out that, in addition to the practical difficulty of achieving any reform in the College of Surgeons, there was a further and perhaps more compelling reason why the College, even if reformed, could not adequately represent the interests of all general practitioners. According to Bird, 'There was a misapprehension existing as to our being reconciled to the College of Surgeons; if all the general practitioners were members of the College of Surgeons, there can be no doubt the energies and efforts of the association would be directed to ascertain the point whether it was practicable so to liberalise the council of the College of Surgeons as to satisfy the demands of its members; but the National Association contained amongst others many gentlemen who were not members of the College of Surgeons, and it was not to be supposed that the College of Surgeons could by possibility admit the whole of those parties, or that it was practicable to make it the kind of institution which was required by those who were engaged in general practice.'

In other words, even if it had been possible to enfranchise within the College of Surgeons those whom the Lancet had called 'surgeons in general practice', this would still have left very many apothecaries in general practice, as well as a substantial number of Scottish-educated physicians in general practice, without any representation.
The deputation from the National Association subsequently had several interviews with the law officers of the Crown for the purpose of framing a charter for a new College of General Practitioners and, in April 1845, the heads of a charter were sent to the Home Secretary. By the time Graham's Bill received its second reading towards the end of April, it was clear that the National Association had managed to win the support of the Home Secretary. In the Commons debate, Wakley asked for confirmation of a report that Graham now considered it 'impossible that the general practitioners should be enfranchised in the College of Surgeons'; Graham replied that he would not say that the door was 'absolutely closed' in that direction, but that 'his fears against, greatly exceeded his hopes... of, any adjustment being at all possible'.

Early in May, the Home Secretary asked the House to recommit the Bill which, by this time, had undergone some fundamental changes in order to meet the expressed wishes of the National Association, by this time clearly established as the major organisation representing general practitioners. Graham told the Commons that he viewed 'the differences which unfortunately exist between the general practitioners of England and Wales and the College of Surgeons' as 'irreconcilable', and that as a consequence he was persuaded it was necessary to incorporate the general practitioners in a separate college. Accordingly, the Bill now proposed the establishment of a Royal College of General Practitioners in Medicine, Surgery and Midwifery, with the Council of the College having the right to nominate two general practitioners to the proposed Council of Health. All general practitioners would, in future, be examined by a joint board of the two older Royal Colleges, followed by a second examination at the Royal College of General Practitioners, and all general practitioners were to be required to become Fellows of the new College.

Graham had opened his speech in the Commons by saying, 'if I could have anticipated the extensive difficulties of this subject, I should not probably have presumed to interfere with it'; and he concluded by saying that if his present Bill were to fail, 'I confess I shall absolutely despair.' In making this comment, the Home Secretary was by no means exagger-
ating the difficulties involved in legislating for what was a deeply divided profession. Perhaps not surprisingly, Graham's revised Bill did not meet with the approval of the Royal Colleges. It came in for equally vigorous criticism from what was by now a minority of general practitioners who still felt that the solution to their problems lay in a democratisation of the College of Surgeons, and that any new college would be of a markedly inferior status. Somewhat ironically, in view of his earlier involvement with the abortive attempt to establish the London College of Medicine, it was Thomas Wakley who was the most prominent spokesman in Parliament for this group of practitioners. Wakley told Graham that under the terms of his revised Bill, the general practitioners would be 'thrust out of their own institution, for the purpose of exercising a miserable privilege elsewhere'; whilst the *Lancet* expressed the view that the general practitioners were finally to be freed from the shackles of 'Rhubarb Hall' (the Apothecaries' Society) only to become the new tenants of the National Association's 'Gallipot Lodge'.

The more serious objections, however, came from the Royal Colleges. On June 18, the College of Physicians sent a memorial to Graham in which they claimed that certain clauses of Graham's Bill were likely to have the effect of lowering 'the standard of the general and professional acquirements of physicians'. In relation to the general practitioners' claims, the College of Physicians objected to the proposal to give general practitioners two representatives on the Council of Health, whilst the College of Physicians also felt it was not proper that 'persons who have undergone a previous examination by physicians and surgeons, should be examined, subsequently, in medicine and surgery, by general practitioners' who clearly constituted, in the eyes of the College, an inferior body. The College of Surgeons also objected to Graham's Bill — in particular, the proposal to give the College of General Practitioners the right to examine in surgery. Graham further amended his Bill in an attempt to meet the objections of the Royal Colleges, and the amended Bill was recommitted on 28 July. By this time, however, it was too late in the Parliamentary session to proceed any further, and the Bill was dropped.
Although Graham declined to introduce a further Bill in the following session of Parliament, the campaign to establish a separate College of General Practitioners continued. Towards the end of 1847, the two Royal Colleges, together with the Society of Apothecaries, began to hold a series of meetings in an attempt to work out a coordinated response to the widespread demands within the profession for reform. In December 1847, the three corporations sent a letter to Sir George Grey, who had by this time replaced Graham as Home Secretary, and in his reply Grey said that it was important 'that the interests of the general practitioners should be considered' and he suggested that some representatives of the general practitioners should be included in the conference. Accordingly, three representatives from the National Institute of Medicine, Surgery and Midwifery — a body which appears to have been a sub-group of the National Association of General Practitioners formed to advance the aims of the parent Association — were invited to join the conference.

Perhaps rather surprisingly, it appeared as though, within two months, representatives of all four organisations had reached agreement on a plan of reform, for in February 1848 the heads of the four delegations signed a document of 'Principles' on which a new Reform Bill might be based. The 'Principles' proposed the establishment of a central Council responsible for the general control of medical education and practice, with one of the Principal Secretaries of State acting as president; the remaining twelve Council members were to be nominated by the crown. Most importantly, however, the statement argued for the establishment of a Royal College of General Practitioners of England. It was agreed that, in future, all general practitioners should be examined by both the Royal College of Surgeons and the proposed Royal College of General Practitioners. However, membership of the Royal College of Surgeons would no longer constitute, on its own, a qualification to practise; members of the College of Surgeons would, in future, only be entitled to be registered after they had also passed the examinations of the College of General Practitioners. The document which had been agreed at the conference thus...
clearly recognised the principle that in future all general practitioners should be required to undergo an examination in all branches of practice. The representatives of the National Institute had, it seemed, managed to persuade the medical corporations to accept a slightly modified version of the plan which had first been adopted by the National Association of General Practitioners in 1845.

Both the statement of 'Principles' and the draft charter for the proposed Royal College of General Practitioners were examined by a Select Committee in 1848. However, in the course of this examination, it quickly became clear that any agreement which had been reached at the conference was more apparent than real; there was continuing disagreement over whether the College of Surgeons would allow the College of General Practitioners to examine in surgery. Speaking on behalf of the National Institute, James Bird said that the Royal College of General Practitioners would 'take power to examine in all branches of medical and surgical knowledge'.26 Bird was quite insistent on this point: 'It was most clearly explained at the conference that the examination before the College of General Practitioners would be in medicine, surgery and midwifery, or any other department of medical science that the council should think fit to order'27 whilst later he added that the College would have 'the unfettered right to examine in medicine and in surgery'.28 He was aware of the fact that the College of Surgeons had formerly objected to the College of General Practitioners holding its own examination in surgery but that objection was now 'completely cancelled'.29

However, when Benjamin Travers gave evidence on behalf of the Council of the College of Surgeons, he indicated quite unambiguously that the College continued to regard surgery as a distinct branch of practice, one which constituted the exclusive province of the College of Surgeons. Asked whether the proposed College of General Practitioners would have the right to examine in surgery, Travers replied, 'No, certainly not; decidedly not; it will be a sine qua non with us that they do not examine in surgery.'30 If the new college were to examine in surgery, 'it would be rendering neutral, or at least superseding our vocation'; it would be 'going out of their
province, and would be decidedly invading ours'. As we have seen, the idea that the College of Surgeons had its own particular 'province' and that the College should confine itself exclusively to that 'province', had traditionally been at the very heart of College policy, and the College was clearly unwilling to give up its exclusive jurisdiction in relation to surgery in favour of a college of mere general practitioners. The College of Surgeons, it seems, was prepared to allow the proposed College of General Practitioners to do nothing more than to take over the examining function, and presumably also the humble status of the Apothecaries' Society which, under the terms of the 'Principles' agreed at the conference, would lose its function of examining in medicine and pharmacy. Thus Travers said that the Council of the College of Surgeons 'understood, of course, that a member of the New College would be equivalent to a member of the Apothecaries Society, and it is upon that basis that we have hitherto legislated'. The Lancet's fears in relation to the new college were not, it seems, unfounded, for the College of Surgeons clearly intended that any College of General Practitioners should be nothing more than a 'Gallipot Lodge'.

Although discussions on the formation of a College of General Practitioners continued until early in 1850, the College of Surgeons continued to insist that it alone had the right to examine in surgery. Thus, at a meeting held on 16 March 1849, the Council of the College of Surgeons stated that it 'objects in the strongest possible manner to any authority for examinations in Surgery being granted to the Society of Gentlemen claiming incorporation as the National Institute of General Practitioners'. Shortly afterwards the discussions between the medical corporations and the National Institute broke down without any agreement being reached; after more than five years of intensive political activity, the plan to establish a separate College of General Practitioners was finally abandoned in the face of continual opposition from the College of Surgeons. Having refused for more than twenty years to enfranchise the 'surgeons in general practice' within the College of Surgeons, the Council of the College had now effectively blocked the
alternative proposal for the establishment of a separate College of General Practitioners.

At this point, it may be appropriate to recap briefly on some of the major aspects of the general practitioners' campaign from the 1820s, and to indicate some of the recurrent issues which underlay the campaign throughout this period. The specific nature of the general practitioners' demands changed from time to time as different organisations assumed the leadership of the general practitioners' movement, but it is nevertheless possible to identify at least two general issues which tended to recur, in one form or another, in virtually all the different phases of the general practitioners' campaign. The first of these issues related to the exclusion of general practitioners from any participation in the affairs of the ruling bodies within the profession, and one of the most persistent demands of the general practitioners throughout this period was for some form of political representation which would allow them to play a part in regulating the affairs of the profession. In the 1820s, the members of the College of Surgeons had demanded a fundamental reform of the structure of the College, with the officers of the College being elected annually by the whole membership in order that each member 'may have a voice in the election of those persons who are to regulate the proceedings of the College'. Following the failure of this early reform plan, there were a number of different plans to establish new institutions which would have the power of examining and licensing practitioners and would allow the general practitioners to participate effectively in their government; in both the London College of Medicine and in the British Medical Association's proposed Faculty of Medicine, for example, the governing Council or Senate was to be democratically elected by all those who held a licence from these institutions. Similarly in the 1840s, much of the support for the National Association's plan for the establishment of a separate Royal College of General Practitioners arose from the exclusion of general practitioners from all political representation within the existing medical corporations and their minimal prospects of ever being enfranchised.

There was one other form which political representation
for general practitioners could take, only briefly touched upon so far. It will be recalled that one of the grounds on which the National Association of General Practitioners had objected to Sir James Graham's original Bill of August 1844 was that the Bill made no provision for general practitioners to be represented on the proposed Council of Health. In Graham's revised Bill of May 1845, however, it was proposed to give general practitioners two representatives on this Council. Although the College of Physicians successfully objected to this proposal, the idea that general practitioners should be represented on any proposed central Council was to be revived in the 1850s, and was to remain as one of the general practitioners' major objectives.

Thus although the specific demands which were made by the general practitioners changed from time to time, it is clear that underlying all those different demands from the 1820s onwards was one fundamental principle, namely that any system of medical reform must ensure some form of political enfranchisement for general practitioners within the governing bodies of the profession, in order that the interests of those who constituted the great majority within the profession could be properly represented. The continued exclusion of general practitioners from any participation in regulating the affairs of the profession was one of the most deeply felt grievances on the part of general practitioners, and the demand for political representation within the profession's governing institutions was one of their most basic and persistent demands.

The second, related, issue concerned the fact that general practitioners had special educational needs which were not being met by the existing medical corporations. As we have seen, the medical corporations continued to reflect the traditional tripartite division of the profession into physicians, surgeons and apothecaries, with an equally rigid division between the three major branches of practice. The general practitioner was not a physician, nor a surgeon, nor an apothecary, for his professional practice was based on the integration of all those branches of practice. Indeed, it was precisely because the general practitioners integrated all branches of practice that they were rejected by the medical
corporations, and denied any representation within them. None of the medical corporations was willing to provide an appropriate examination and licence for general practice, or even to recognise the importance of general practice, for each was concerned only with the particular branch of practice for which it was responsible, with none of them taking any clear responsibility for the teaching and examining of midwifery. For this reason it was important, from the perspective of general practitioners, that any new institutions which were established should not perpetuate this increasingly outdated tripartite structure but that, on the contrary, they should seek to break down the traditional divisions within the profession and that, above all, proper provision should be made for the education and examination of those who acted as general practitioners. Thus within the proposed London College of Medicine in the early 1830s, the intention was to ‘cast aside the absurd distinctions which now exist in the profession’. The examinations of the College were to integrate all branches of medicine, surgery and midwifery, and all practitioners who were licensed by the College — even those who intended to specialise in a single branch of practice — would first be required to undergo a comprehensive examination in all branches of practice for the security of the public. The British Medical Association similarly aimed to break down those ‘most unnatural divisions and degrading distinctions’ which were institutionalised in the tripartite structure; within the Association’s proposed Faculty of Medicine, all branches of the profession were to be integrated and all those who were licensed by the Faculty were to be free to practise in all branches of the profession. Finally, as we have seen, it was intended that the proposed Royal College of General Practitioners should take power to examine all future candidates ‘not in medicine alone, not in surgery alone, not in midwifery alone, or pharmacy alone, but in all those branches that are essential to constitute an efficient general practitioner’. Thus a second major theme of the general practitioners’ campaign may be said to have been their rejection of the traditional separation between the different branches of the profession and, in particular, their demand that proper provision should be
made for the education and examination of general practi-
tioners in all branches of practice.

Whilst these two issues were present in the general prac-
titioners’ campaign almost from the beginning, a third issue,
relating to the establishment of a medical register, came
into particular prominence from the late 1840s and proved
to be a further focus of disagreement between the general
practitioners and the Royal Colleges. It is important to note,
however, that this disagreement did not centre on the
desirability of registration as such, for the necessity for some
form of registration had been accepted by all sections of the
profession and had been a feature of every Bill introduced
into Parliament from 1840 onwards. Thus whilst it was the
general practitioners who were particularly vehement in
their demands for a register of qualified practitioners, since
they felt this would give them some protection against the
competition of unqualified practitioners, even the con-
servative Royal Colleges were not opposed to the principle
of registration. In his evidence to the 1847 Select Committee
on Medical Registration, for example, the president of the
College of Physicians, J A Paris, stated that the College had
no objection to a register, whilst the College registrar,
Francis Hawkins, went considerably further, and expressed
the view that it was ‘very desirable that the medical profession
should be registered in a manner better than it is now’. For
the College of Surgeons, the president, William Lawrence, saw
no objection to ‘a registration of medical practitioners that
should set forth the qualifications under which they practise’
whilst Sir Benjamin Brodie, a member of the Council of the
College and a former president, also felt that a system of
registration of all qualified practitioners ‘would be a very
good thing; it would be popular with the profession, and
rather useful for the public’.

There was, therefore, little serious disagreement within the
profession on the desirability of registration. There was major
disagreement over the precise form which the registration
should take. As part of their attempt to break down the
traditional divisions within the profession, the general prac-
titioners wanted a single register which would simply list in
alphabetical order all qualified practitioners and give all
registered practitioners a similar legal status, with the legal right to perform the complete range of medical and surgical tasks. The Royal Colleges, on the other hand, whilst not being opposed to the principle of registration, insisted that there should be not one common register for all practitioners, but rather three separate registers, one for physicians, one for surgeons, and one for apothecaries; in this way, the three traditional 'orders' of the profession, each with its own exclusive, legally defined sphere of practice, would be maintained.

The issues involved in this debate were defined particularly clearly as the result of the introduction of a new medical reform Bill — the seventh since 1840 — by Thomas Wakley in April 1847. Wakley's Bill made provision for all qualified practitioners, whatever their former legal status, to be listed in a common register, with every registered practitioner enjoying similar legal rights — including the right to recover charges for advice, visits and attendance, the right of exemption from service on juries and inquests, and the right to practise medicine 'throughout that part of the United Kingdom for which his certificate was issued', that is to say, England and Wales, Scotland, or Ireland. Equally importantly, however, Wakley's Bill also included an interpretation clause which stipulated that 'the words "Medicine" and "medical", when used in this Act, shall also mean and include the words "Physic", "Surgery", and "surgical"'. The provision for registration contained in Wakley's Bill, together with this interpretation clause, would thus have effectively undermined the tripartite structure of 'orders' within the profession.

In view of this fact, it is not surprising that the College of Physicians petitioned against Wakley's Bill. The Council of the College of Surgeons similarly decided, at an extraordinary meeting held on 3 May 1847, to oppose Wakley's Bill, and the president and vice-presidents were instructed to communicate with the Secretary of State on the subject of the Bill. At the Council meeting on 10 June, it was reported that the president and vice-presidents had petitioned the Commons against Wakley's Bill which, they argued, would have the effect of 'confounding the existing distinctions in
the Profession, and reducing all its Members to one level'.

Although Wakley subsequently withdrew his Bill, he did so only after successfully moving for the establishment of a Select Committee to inquire into the registration of medical practitioners. In their evidence before that Committee, the Royal Colleges made their position quite clear. Speaking on behalf of the College of Physicians, the president of the College held that the effect of Wakley's Bill, which at that stage had not yet been withdrawn, would be to create one class of medical practitioner. He argued that 'the highest grade would cease to exist', with the result that medicine would no longer be a learned profession. Although not opposed to registration as such, he held that 'medical men should be registered in classes or grades'. The registrar of the College of Physicians, Francis Hawkins, similarly held that 'if the registration were to be formed upon the principle of their [the three “orders” of the profession] being placed together, it would tend to destroy those distinctions which have been found to be beneficial to the whole profession, and also to the public.' The effect of Wakley's Bill, he argued, would be to 'throw all the orders of the profession into one class ... I think the attainments of those who have hitherto been the most highly educated in the medical profession would undoubtedly be lowered.'

Wakley's Bill was attacked in similar terms by other representatives of the College of Physicians. Thus Henry Holland held that the Bill was 'pernicious'; it was, he argued 'exceedingly important for the profession and the public that there should be grades in the profession, and that any measure that might tend to abolish those grades, or even to weaken their influence, would be as injurious to the public as to the profession.' The physicians' concern to maintain a distinct legal status which would clearly separate them from
the 'lower orders' of the profession was, perhaps, most clearly expressed by the president of the College in relation to something which, to the modern reader, might seem a trivial change in the legal status of the physician but which to the College was clearly of considerable importance. For a number of years, both surgeons and apothecaries had had the legal right to sue a patient for recovery of charges. Physicians, as befitted gentlemen, were legally considered as attending patients for an honorarium and, as such, they were unable to maintain an action for fees; in this way, the professional activities of the physician were defined as lying outside of the context of normal commercial or market transactions. Wakley's Bill, however, proposed to give all registered practitioners similar legal rights, including the right of recovering payment of charges for their attendance. The College of Physicians was, as ever, alert to any threat to its exclusive status, even from such a minor change in the law. 'We object to that very much', said their President, 'we consider that the physician would under those clauses be converted into a tradesman; we should feel that we had lost caste by allowing those clauses to pass.'

Like the College of Physicians, the College of Surgeons also objected to any form of registration which did not differentiate between the different 'grades' within the profession. Thus William Lawrence, president of the College of Surgeons, criticised 'those levelling principles of equality which are found to be injurious wherever they exist in practice', and he went on to argue that 'If you have all on one level, it must be by depressing those who are higher to the level of those who are lower in public opinion and confidence.' Lawrence considered that registration in classes or grades would be 'the only kind of registration which would give the public proper information'. Sir Benjamin Brodie similarly held that the effect of Wakley's Bill would be 'to confound all grades of the profession together', a process which he held to be 'not at all desirable'. George James Guthrie, a Councillor and former president of the College of Surgeons, did not object to a register of qualified practitioners, but held that 'they should be kept distinct as to their being physicians or surgeons, or surgeon-
apothecaries. Using a particularly appropriate medical analogy, he went on to argue that 'a certificate should say the individual is qualified to practise as a surgeon or as a physician, or a general practitioner as the case may be; but it does not do so, and that is what the Colleges have objected to, as pounding us all up in the same mortar, in fact.'

In relation to the question of medical registration, therefore, the crucial question was not whether there should be a register of qualified practitioners, for by this time all sections of the profession had accepted the need for some form of registration which would enable the public to differentiate between those practitioners who were qualified and those who were not. Rather, the central question was whether the three 'grades' of the profession should be registered separately, thus maintaining a separate legal status for physicians, for surgeons, and for apothecaries, or whether, as Guthrie had put it, all practitioners should be 'pounded up in the same mortar' in a common register.

In summary, therefore, we may say that the general practitioners' campaign for reform was characterised by two longstanding demands which were present almost from the very beginning of their campaign, whilst a third issue, which further divided the general practitioners and the Royal Colleges, came into prominence from the late 1840s. These two longstanding demands of the general practitioners were, firstly, that any programme of reform must recognise the existence of general practitioners by giving them some form of political representation within the profession and, secondly, that any proposals for reform must make adequate provision for the education and examination of general practitioners in all branches of practice; the third issue related to the disagreement between the general practitioners and the Royal Colleges as to the precise form which the registration of medical practitioners should take. Bearing these three major issues in mind, in the next chapter we shall examine in some detail the culmination of more than thirty years' agitation for reform — the Medical Act of 1858 — and we shall be concerned, in particular, to examine the extent to which the Royal Colleges on the one hand, and the general practitioners on the other, were successful in shaping the
Act in accordance with their own interests. To what extent, then, did the 1858 Act meet these three basic demands of the general practitioners in relation to political representation, education and registration?
The Medical Act of 1868 is generally regarded as a major legislative landmark — perhaps the major legislative landmark — in the development of the medical profession, for in establishing the General Medical Council and in requiring the Council to maintain a register of all qualified practitioners the Act established an important part of the institutional framework of the modern medical profession in Britain. Clearly, therefore, some understanding of the processes leading up to the passage of the Act, and of the consequences of the Act, is important for a broader understanding of the development of the medical profession as we know it today. In this chapter, we shall be concerned with an analysis of the processes leading up to the 1858 Act and of the part played by the Royal Colleges and the general practitioners' organisations in shaping the Act, whilst, in the next chapter, we shall examine some of the major consequences of the Act for the subsequent development of the profession.

As we have noted, the first Medical Reform Bill had been introduced into the House of Commons in August 1840; throughout the 1840s other reform Bills were introduced at intermittent intervals. By the mid-1850s, it was clear that the medical reform movement within Parliament was growing in strength; further Bills were introduced in 1854 and 1855, whilst in the early part of 1856, two very different Bills were introduced into the Commons and were referred to a Select Committee, which subsequently devised and reported a Bill of its own. This flurry of Parliamentary activity clearly worried the Royal Colleges in London, for in the summer of 1856 they formed a semi-formal but confidential alliance which held regular meetings, and which
played a major part in shaping and modifying subsequent Bills, including that which eventually became the 1858 Medical Act. In order to understand the part played by the Royal Colleges in shaping the 1858 Act, therefore, it is necessary to examine the development of this alliance, and the events which gave rise to it.

In February 1856, T E Headlam introduced into the Commons a Bill 'To alter and amend the Laws regulating the Medical Profession'; two months later a second Bill 'for Regulating and Improving the Medical Profession' was introduced by Lord Elcho. The precise details of these two Bills need not concern us here, but it is important to note that Headlam's Bill was considerably more sympathetic to the claims of the Royal Colleges than was that of Lord Elcho. Thus Headlam's Bill proposed not only the registration of practitioners in classes or 'grades', but also a significant extension of the powers of the Royal Colleges in relation to the examination and licensing of practitioners, for in future all practitioners were to be required to be examined by and to be enrolled in the appropriate Royal College. In marked contrast, the Bill of Lord Elcho proposed the common registration of all practitioners and in its provisions relating to the examination and licensing of candidates sought to protect the position of the universities — particularly the Scottish universities — rather than that of the Royal Colleges.¹

The College of Physicians petitioned in favour of Headlam's Bill, subject to certain minor amendments and, in April 1856, the president and registrar of the College sent a memorandum to the Select Committee to which both Bills had been referred. In this memorandum, they indicated their support for the general principles of Headlam's Bill and their opposition to Elcho's Bill which, they claimed, proposed to grant 'perfect equality to all licences and diplomas', a principle which the College found unacceptable.² When the Select Committee reported, however, they recommended a Bill which was unlike either Headlam's or Elcho's.³

It was at this stage that the Royal Colleges, clearly expecting further legislation to be introduced in the next session of Parliament, began to form themselves into a well-organised pressure group. Rather curiously, the Annals of the College
of Physicians contain relatively little information about the formation of this alliance between the Royal Colleges, but the minutes of the Council of the Royal College of Surgeons are rather more helpful and, from this information, it is possible to piece together the part played by both Royal Colleges in the development of this alliance.

At a meeting of the Council of the College of Surgeons held on 7 August 1856, the president of the College, Benjamin Travers, reported that he and six other prominent members of Council, 'having taken into consideration what in their opinion should form the basis of a Medical Bill', had held two meetings with the president, the registrar and four other representatives of the Royal College of Physicians. At these meetings there had been 'general concurrence with certain Elementary Propositions or Principles on which such Bill might be founded'. The Council of the College of Surgeons agreed that the president and the six other members of Council who had been involved in these meetings should constitute a committee with authority to confer with other interested parties.

At the next meeting of the College Council, on 16 October, the president reported that three further conferences had taken place with representatives of the College of Physicians and that, at two of these meetings, a deputation from the Society of Apothecaries had also attended. It had been decided that, in an attempt to win support for the Bill being drawn up by the London corporations, a larger conference should be held at the end of October, and that representatives should be invited from all the Royal Colleges in England, Scotland and Ireland, from the London Society of Apothecaries, and from the Glasgow Faculty of Physicians and Surgeons.

This conference was duly held at the Royal College of Surgeons in London on 21, 23 and 24 October 1856, with the president of the College in the chair. The minutes of the conference indicate that, on the opening day, proposals for a Medical Bill — presumably drawn up by the London corporations at their earlier meetings — were circulated, and that the whole of the conference was taken up with a consideration of this Bill. It was agreed that the observations of the various delegations should be marked 'confidential', and that 'the
proceedings of these Conferences be considered strictly confidential. The London colleges appear to have been successful in persuading the other corporations to accept their proposals, subject to what seem to be a few minor amendments, and at a special meeting of the Council of the College of Surgeons, held on 30 October, the Council was informed that proposals for a Medical Bill had been discussed, and ‘the heads of a Bill settled’. Following this conference, the Scottish and Irish delegates departed, but further meetings took place between the two London Royal Colleges and the Society of Apothecaries, and on 11 December, the President of the College of Surgeons was able to report to his Council that ‘the subject of the Bill was, in his opinion, progressing favourably’. With the principles of the Bill apparently agreed, the London corporations now needed to find a sympathetic MP prepared to introduce their Bill into the Commons. Headlam’s Bill of February 1856, it will be recalled, had been broadly sympathetic to the claims of the Royal Colleges and, indeed, a number of clauses in Headlam’s Bill had been taken directly and incorporated into the Bill drawn up by the Royal Colleges. Headlam was accordingly approached, and agreed to introduce the Bill.

One final obstacle remained to be overcome before the Colleges’ own Bill could be introduced into the Commons. Although no government Bill on this subject had been introduced since Sir James Graham’s last Bill of 1845 — all subsequent Bills being private members’ Bills — the Royal Colleges appear to have been worried that, on this occasion, the government might introduce its own Bill, perhaps based on the recommendations of the Select Committee of the previous session; for the chairman of the Select Committee had been W F Cowper, and Cowper had not only taken a keen interest in the subject but, as president of the Board of Health, he was also a member of the government. Accordingly, the heads of the three London corporations made representations to the Prime Minister, Lord Palmerston, in which they informed him that they proposed introducing a Bill of their own and asked that, in the light of this information, the government refrain from bringing in any Bill until the Bill projected by the corporations had been prepared and considered.
It is not known whether, at this stage, Cowper was thinking of bringing in a Bill, but on 27 January 1857, John Simon, the Medical Officer to the General Board of Health, wrote on behalf of Cowper to the registrar of the College of Physicians, requesting a copy of the corporations' Bill at the earliest opportunity, for Cowper apparently felt that he 'must be ready at the opening of Parliament to state his intentions on the subject'. No government Bill was subsequently brought forward, though one cannot, of course, be certain whether this was a result of the representations made by the London corporations or of some other considerations. In any event, the outcome was that desired by the London corporations, for the absence of a government Bill, for whatever reason, left the field clear for the introduction of the corporations' own Bill.

On 16 February 1857, the Council of the College of Surgeons held a special meeting at which the Draft Medical Bill was considered and approved. Early in May, shortly before the Bill was to be introduced into the Commons, a further meeting was held between Headlam and representatives of the two Royal Colleges and the Society of Apothecaries.

The Bill which had been drawn up by the London corporations was given its first reading in the Commons on 13 May 1857 and, not surprisingly, the Bill itself clearly reflected the interests of those who had drafted it. In particular, the Royal College of Physicians, as the most prestigious of all the medical corporations, appears to have played a dominant part in the drafting of the Bill, for the interests of the College were meticulously protected in every detail. The Bill proposed to establish a governing Council for the profession, to be composed of seventeen persons chosen by the corporations and universities in Britain, together with six persons nominated by the crown. Separate registers were to be kept for physicians and for surgeons and, significantly, the term 'physician' was defined in a very restrictive manner in order to ensure that only those who practised as physicians in the sense in which the College understood the term could be so registered. Thus clause fifteen of the Bill stated that in 'The Physicians Register', as it was to be called, were to
be listed the names of all those who were licensed to practise as physicians, 'and not engaged in the Art and Mystery of an Apothecary, or in the Practice of Pharmacy'. The College was clearly being very careful to ensure that the status of the physician would not be diluted in any way.

It will be recalled that there was another aspect of the status of the physician about which the College of Physicians was particularly sensitive, relating to the proposal to give physicians the legal right to recover charges for attendance and advice. When this proposal had been included in the 1847 Bill of Warburton and Wakley, the College had objected strongly, saying 'the physician would under those clauses be converted into a tradesman'. Nine years later, the president and registrar of the College reiterated this point in the memorandum which they submitted to Cowper and the other members of the 1856 Select Committee: the College was 'anxious that physicians should not have their social position lowered by having the power given to them of recovering charges'. Given the prominent part played by the College of Physicians in drawing up the Bill which was introduced by Headlam, it is not surprising that the Bill proposed to leave the position of physicians unchanged in this respect; although it was proposed to give registered practitioners in general the right to recover charges, it was stated specifically that this right did not extend to those who were registered as physicians. The traditionally distinct and privileged legal status of the physicians as a separate 'order' within the profession was, under this Bill, to be preserved in all respects.

In addition, the powers of the College in relation to the examination and licensing of practitioners were to be considerably extended, for the Bill stipulated that, in future, anyone wishing to be registered as a physician would be required to have passed the examination of, and to have been enrolled as a member in, the appropriate Royal College of Physicians in England, Scotland or Ireland. Thus whilst those persons who had obtained a university degree in medicine prior to the passage of the Bill could register on the strength of that qualification, a university degree obtained after the passage of the Bill would not, on its own, entitle anyone to be registered until that person had also been
examined by, and enrolled in, the appropriate Royal College of Physicians. This provision would, of course, have greatly strengthened the powers of the Royal Colleges, and simultaneously weakened those of the universities, particularly the Scottish universities which, by this time, were producing large numbers of well qualified graduates. As we shall see shortly, there were other parts of the Bill which would have had the effect of further centralising control of medical education and licensing in the hands of the Royal Colleges, and particularly in the hands of the Colleges of Physicians in England, Scotland and Ireland.

Perhaps rather surprisingly, it seems that in the negotiations involved in the drafting of the Bill, the Royal College of Surgeons had agreed that 'The Surgeons Register' should contain the names of both surgeons and apothecaries, and that those who wished to register as surgeons would, in future, be required to pass three separate examinations, in medicine, surgery and midwifery. This provision was presumably designed as a concession to the demands of the general practitioners, but the particular institutional arrangements which were proposed in the Bill for carrying this provision into effect would have ensured that professional education became even more highly centralised under the control of the Royal Colleges, for the examinations were to be conducted by the medical corporations with no participation from the universities. This provision would have ensured the continued dominance of the Royal College of Surgeons in relation to the practice of surgery, for it was stipulated that in England the examination in surgery was to be conducted exclusively by the College of Surgeons, and that all surgeons were to be required to pass the examination of, and to be enrolled in, the Royal College of Surgeons in London. However, the greatest beneficiary of the new examination arrangements proposed in the Bill would undoubtedly have been the Royal College of Physicians, for the College was to be involved in the examinations in both medicine and midwifery which were to be obligatory for all those who wished to register as surgeons. Thus the Bill not only proposed to maintain the class of physicians as a distinct 'order' within the profession and to give the College
of Physicians a monopoly in relation to the licensing of physicians, but it also proposed that the College should be involved in the examination of *every single person* who wished to practise medicine, whether as a physician or as a surgeon. This imperialistic strategy on the part of the College of Physicians, had it succeeded, would have given the College far greater powers in relation to the entire profession than those ever enjoyed by any single corporation.

Finally, the Bill stipulated that any physician or surgeon who moved from one part of the United Kingdom to another would have to enrol as a Member or Licentiate in the appropriate College of Physicians or Surgeons for that part of the Kingdom to which he had moved, and any practitioner not so enrolling within three months was to be struck off the register. Thus any practitioner — no matter how well qualified — following the well-worn path of medical migration from Scotland to England, would have been required to enrol in either the Royal College of Physicians or the Royal College of Surgeons in London. The control of medical practice in England by the two London colleges would have been almost total.

In the debate on the first reading of the corporations' Bill, two contributions were, perhaps, of special significance. Cowper, the president of the Board of Health, pointed out that the Select Committee of the previous year had, amongst other things, embraced the principle 'of fixing a minimum standard, without having attained to which no one could obtain a licence to practise. In order to come up to that standard it was necessary that a surgeon should know something of medicine, and that a physician should be in some degree acquainted with surgery. This basic principle was not, of course, met by the corporations' Bill, for it proposed to retain a class of 'pure' physicians.

The second significant intervention came from Lord Elcho, who suggested that 'It was possible ... that there might be a unanimous feeling among the medical corporations in favour of this Bill, without a corresponding unanimity among the great body of the profession.' Elcho indicated his intention to bring in an alternative Bill, which he duly did on 15 May, two days after the first reading of the Bill drawn up by the
medical corporations. Very briefly, the major features of Elcho's new Bill were the establishment of a controlling Council for the profession, the members of which were to be nominated by the crown rather than by the medical corporations and universities, a system of common preliminary and professional examinations to be conducted by boards representing both the universities and the corporations, and a single register for all practitioners. Such a Bill was, of course, unlikely to find favour with the London corporations.

The College of Physicians in London immediately petitioned the House of Commons in support of Headlam's Bill — which was, of course, the corporations' own Bill — and against Elcho's; whilst the medical corporations also published a joint statement entitled 'Reasons, on behalf of the Medical Incorporations, in favour of Mr Headlam's Medical Bill, and against that of Lord Elcho'. On 10 June 1857, the president of the College of Surgeons reported to the College Council that 'the several Corporations were still acting with the utmost unanimity', and that they had had a meeting with the Prime Minister in order to express their opposition to Elcho's Bill.

Headlam's Bill came up for its second reading in the House of Commons on 1 July 1857 and met some severe criticism. Mr Crawford, who was a co-sponsor of the Bill introduced by Lord Elcho, said that Headlam's Bill 'betrayed a greater anxiety to consult the interests of the corporations than he thought the House would sanction', and he indicated that he did not feel disposed 'to continue these corporations in the possession of privileges which were no longer suited to the spirit of our times'. The Bill was, he said, 'in no way calculated to advance the interests of the medical profession, though it would increase the privileges of certain corporations'. Mr Black similarly pointed out that the Bill 'gave such immense power to the corporations', whilst he also objected to the Bill on the grounds that there 'ought not to be any class distinctions in the medical profession'. Lord Elcho objected to the proposal to give the corporations 'powers which they had not heretofore possessed', and pointed out that Headlam's Bill proposed 'not that they
should have a fair share of power — to which he should not object — but that they should have a complete monopoly'.

The Bill also came in for criticism from Cowper, who indicated that he found it difficult to justify the proposal to deprive the universities of the power of licensing practitioners, and to centralise this power in the hands of the Royal Colleges. He also objected to the proposal to maintain a class of 'pure' physicians, saying that Headlam's Bill 'exempted the College of Physicians from the necessity of having an examination in the practice of surgery: so that, after this Bill passed, the physician would still be a man who with haughty and fastidious contempt for a necessary branch of the art of healing, might ignore what the humblest surgeon was compelled to know'. The Royal Colleges, however, were not without their supporters; a number of MPs spoke in favour of the maintenance of what one of them called 'professional aristocracies', and when the vote was taken, Headlam's Bill was given a second reading by 225 votes to 78, a very comfortable majority of 147. Elcho took this as an indication of support for Headlam's Bill rather than his own, and immediately announced his intention of withdrawing his own Bill.

Thus far, things had gone very much according to plan, at least as far as the Royal Colleges were concerned. It soon became clear, however, that Headlam's Bill was running aground on what was for private members' Bills a familiar problem, for that session of Parliament was moving towards a close and it was clear that, unless the government was prepared to take up Headlam's Bill, there would be insufficient time in that session of Parliament for the Bill to pass. Early in July 1857, Headlam wrote to the College of Surgeons saying that although his Bill had passed a second reading, there was 'no chance of forcing the bill through this session'. He had, it seems, already approached the Prime Minister for support, but Lord Palmerston had 'too much on his shoulders', and had declined to take up the Bill. As a result, Headlam informed the College that he was dropping the Bill.

The next significant development came on 11 December 1857, when Cowper announced his intention of bringing in a Bill in the near future to regulate the qualifications of
medical practitioners. Cowper, it will be recalled, was particularly well informed about matters relating to the medical profession, for he had been president of the Board of Health since 1855 and had also chaired the Select Committee of 1856 which had examined the Bills of Headlam and Elcho. It is reasonable to suppose that Cowper's announcement would not have been welcome news for the Royal Colleges, for in the debate on the second reading of the Bill which had been drawn up by the corporations and introduced by Headlam, Cowper had clearly indicated that he had little sympathy with some of the major provisions of the Bill; indeed, Cowper had gone so far as to describe the corporations' Bill as 'an ill-advised attempt to patch up the defects of the existing system', implying that he himself had something much more radical in mind. Before Cowper could introduce his Bill, there was a change of government, for in February 1858 Lord Palmerston's government was defeated on another issue — the Conspiracy to Murder Bill — and Lord Derby became Prime Minister. Cowper was, of course, now simply a private member, but he nevertheless went ahead with the introduction of his Bill, which received its first reading on 23 March 1858.

Once it had become clear that Cowper was still going ahead with his Bill, the London corporations arranged a hastily convened series of meetings in order to coordinate their activities. On 4 March 1858, the Charter and Conference Committee of the Royal College of Physicians passed two resolutions, the first of which asked that a meeting of the three London corporations 'should forthwith be convened', whilst the second expressed the opinion that 'no time should be lost in asking the support of Government for the Medical Bill of last Session, which was framed and promoted by the General Conference of the United Kingdom, and the principles of which obtained the sanction of a large majority in the House of Commons'. The College, in other words, wanted to see the reintroduction of the Bill which had been drawn up by the corporations, and introduced by Headlam in 1857. The proposed meeting of the three London corporations was duly held on 10 March, and on 15 March, the Council of the College of Surgeons held a special meeting
to receive a report on this conference. The Council suggested that support should once again be sought from the Scottish and Irish corporations, and this proposal was accepted by the two other London corporations at a further meeting on 16 March.

All this activity on the part of the London corporations immediately prior to the introduction of Cowper's Bill suggests that they may well have been anxious about what the Bill might contain, and for good reason. Although Cowper knew a great deal about the medical profession, there is little doubt that the Bill itself was largely drafted by John Simon, whom Cowper had appointed as Medical Officer to the Board of Health in 1855, and with whom he had a close working relationship. Simon's involvement in drafting the Bill was well known to contemporaries, and is confirmed by an office memorandum written by Simon in 1858. Since this memorandum sets out very clearly the principles and objects of the Bill, it is worth studying in some detail.

Simon began the memorandum by suggesting that there were five areas in relation to which there was general agreement within the profession on the need for reform. These five areas were:

1. the necessity for a legal definition to be given to the term 'qualified medical practitioner';
2. the need for an authentic register to be kept;
3. it should be a misdemeanour for any person falsely to assume a title implying that person to be legally qualified;
4. provision for removal from the register of any person found guilty of disgraceful offences;
5. registered practitioners should be entitled to practise throughout the United Kingdom.

Whilst Simon was probably correct in pointing out that there was general agreement on the necessity for reform in relation to each of these areas, it is equally correct to point out that, particularly in relation to the first two areas, there was no general agreement on the shape which those reforms should take. Thus whilst there may have been agreement on the need for a legal definition for the term 'qualified medical practitioner', there was none amongst the different sections of the profession on what form that definition should take,
just as there was no agreement on the precise form which
an 'authentic register' should take. Significantly, in relation
to both of these major issues which divided the profession,
Simon came down firmly in favour of the kind of argument
which had long been advanced by many general practitioners,
and equally firmly against the position adopted by the Royal
Colleges.

In relation to the legal definition to be given to the term
'qualified medical practitioner', Simon set out his position
in some detail: 'if the "qualified medical practitioner" is
to be in any special sense recognised at law, and in even the
smallest degree protected and privileged against competition,
ample security must be taken, as regards future admission
to the profession, that the legally-qualified medical prac­titoner shall be a well-qualified medical practitioner.'36
Simon's conception of what constituted a well-qualified
medical practitioner was, however, very different from the
view traditionally held by the Royal Colleges. He pointed
out that 'corporations of physicians and surgeons may award
distinctive titles of honour to persons of riper age who show
eminent qualifications for one or the other branch of
practice', but he went on to argue 'such distinctive titles
ought not, it is held, to be given except as super-additions
to the primary and general title which should mark every
member of the medical profession'. For Simon, it was
unacceptable that, in future, any practitioner should be
able to register as a legally qualified practitioner on the
strength of a single qualification in one branch of practice
only; it was, he wrote, 'an insecure arrangement for the
public ... that candidates should. receive any legal recog­
nition as medical practitioners, founded on their exclusive
knowledge of one department of medicine'. This view was,
of course, bound to bring Simon and Cowper into conflict
with the Royal Colleges, and particularly with the Royal
College of Physicians, which had always argued that the
different areas of medicine should be seen as separate and
distinct branches of practice which were best left to equally
separate and distinct groups of practitioners. Simon,
however, was in no doubt about what was required: 'If legal
status is to be given to the medical practitioner, it ought to
be on the basis that from all future candidates there will be expected, first of all, the knowledge which would render them . . . competent for general practice. On this first major area of intra-professional disagreement, Simon thus came down firmly in favour of the integration of the different branches of practice, something for which many general practitioners had long been arguing.

It was, therefore, a fundamental intention of Simon in drafting the Bill that in future all practitioners should be required to undergo a thorough education and examination in all major areas of practice. Moreover, Simon also made it clear that, if an adequate system of education and examination in all branches of practice was to be developed, the existing licensing authorities could not be relied upon to make the necessary reforms. Like the general practitioners, he viewed the medical corporations with suspicion, whilst his opinion of most university medical schools was not, it seems, very much higher. Thus he argued that the existing system did not give adequate security to the public, and the task of providing that security could not be left to what he called the 'mutually independent actions of 21 irresponsible authorities'.

The objective of ensuring that all future practitioners would be properly qualified — in the sense in which Simon and Cowper understood the term 'qualified practitioner' — was to be achieved in the Bill by the creation of a General Council of Medical Education and Registration, to be given wide-ranging powers in relation to the control of medical education and examinations. The powers of the Council were defined in clause four of the Bill, which stipulated that the Council was to assume responsibility for 'Defining the Qualifications and conditions in respect of general and professional Knowledge and Course of Study . . . which shall entitle Persons . . . to be registered'. In order to ensure that all practitioners would in future be qualified in all major branches of practice, the Council was to be given powers to require any two or more examining bodies in any part of the United Kingdom to cooperate in conducting joint examinations and to establish or to provide for the establishment of examiners in any branch of practice in
which the Council felt that the existing examinations were inadequate. These powers to control and to direct the examinations of the existing licensing bodies were, as we have noted, wide-ranging, but they were central to the major objective of the Bill stated in the opening words of the preamble: 'Whereas it is expedient that the Qualifications of Persons seeking to enter the Medical Profession should be tested and declared by competent authorities'. Since the existing licensing authorities could not rely upon to make the necessary reforms, the Council was to be the major instrument for effecting reforms in the education and examination system and, if the Council was to be able to do its job properly, it was essential that the powers of the Council should be 'more than nominal', as Simon put it in his office memorandum of 1858.\textsuperscript{49} Clause four of the Bill, which gave the Council the required powers, was at the very heart of the Bill, not only for Simon and Cowper, but also for the British Medical Association which had by this time clearly emerged as the single most important organisation representing general practitioners.

In relation to the second major problem which divided the general practitioners and the Royal Colleges — the question of the precise form which registration should take — Simon came down once more on the side of the general practitioners. Thus Simon argued firmly against the principle of registration in classes or 'grades', saying that 'it would be a task of extraordinary difficulty under the present circumstances of the profession, to define each of the three classes in the strict language of legislation'.\textsuperscript{41} The Bill accordingly made provision for all registered practitioners, whatever their former legal status, to be listed alphabetically in a single register. Moreover, the Bill also proposed to give all registered practitioners the right to recover charges in a court of law, thus raising for the College of Physicians the awful prospect that in law the activities of the physician might be seen in the same light as those of a common tradesman.

The third of the general practitioners' demands involved the claim for some form of political representation within the profession and, on this point, the intention behind the Bill of Simon and Cowper was not entirely clear. Whilst
Simon clearly felt obliged to make provision for the medical corporations and the universities to appoint representatives to the new Council, he was understandably anxious that the Council should not simply 'guard the vested interests of corporate institutions', and that the Council should carry out properly the major functions which were to be assigned to it under the Bill. Accordingly, the Bill also provided for the appointment of six independent members of the Council, to be nominated by the crown. Clause five of the Bill expressly stated that these six persons were not to be members of Council or office bearers in any of the corporations, though it is not clear whether the intention was that these additional six persons should be appointed from amongst rank-and-file practitioners, from amongst groups such as medical teachers not holding office in any of the corporations, from amongst lay persons, or — perhaps most likely — from amongst a mixture of these groups. Whatever the intention behind clause five may have been, it did not exclude general practitioners from being appointed to the Council, whilst it clearly excluded the possibility that additional representation could be given to the medical corporations.

In summarising the major provisions of the Bill of Simon and Cowper, we may say that in relation to two of the demands of the general practitioners — the demand for an integrated examination system embracing all branches of practice and for a single register — their demands were more or less met in full by the Bill; whilst in relation to their third demand — for political representation — the door was at least left open, even if only slightly so, for general practitioners to be appointed to the Council. At the very least, therefore, it is probably fair to say that the general practitioners had considerably more reason to be pleased with the Bill than did the Royal Colleges.

Given the nature of Cowper's Bill, it is not surprising that when the Bill was introduced, it was welcomed by those organisations and individuals which had been in the forefront of the campaign for medical reform. On 10 April 1858, the Lancet expressed its support for Cowper's Bill, saying that 'Everything now is culminating to the point of success.' The only significant reservation which the Lancet had in
relation to the Bill was that it did not contain a penalty clause for unqualified practice, something for which the Lancet had long argued, but which was never likely to obtain majority support within Parliament. The following week the Lancet published a detailed analysis of Cowper's Bill and reiterated its support for the Bill, whilst on 24 April the Lancet called on all medical reformers — 'those who have fought the battle over and over again, as well as others who have more recently joined the ranks of the veterans in the cause' — to unite and make 'one more grand effort' to promote the success of Cowper's Bill.

The British Medical Association, representing the great majority of general practitioners, also welcomed the introduction of Cowper's Bill. At a meeting of the Association's Medical Reform Committee, held on 1 April, it was decided to ask Cowper to make a few minor amendments to the Bill, and to recommend the Bill with such alterations to the membership of the Association at large. A further meeting of the Medical Reform Committee was held on 23 April, after which the Committee had a long interview with Cowper, who indicated his willingness to accept the alterations suggested by the Association, and to have the appropriate amendments made in the committee stage of the Bill. On behalf of the Medical Reform Committee, the chairman, Sir Charles Hastings, signed a petition to be presented to the Commons in favour of Cowper's Bill, and it was decided to ask all branches of the Association similarly to petition in favour of the Bill. The Lancet described Cowper's acceptance of the alterations suggested by the Association as a 'graceful and important acquiescence in the wishes of the profession', and it said the duty of all sincere reformers was to support the Bill: 'If Mr. Cowper be properly supported there is now good reason to believe that his measure will be carried.'

About three weeks later on 15 May, a large deputation from the British Medical Association saw Cowper once more, together with the new Home Secretary, Spencer Walpole, in order to reiterate their support for the Bill. Two points made by the BMA are of special significance. The first of these was made by Dr Budd and related to the proposed
powers of the central Council: 'it would be desirable there should be a central council, which should not only fix the standard of education for medical practitioners, but that they should also have the power to enforce it; without that the powers of such a council would be useless.' The delegation clearly shared Simon's view that it was essential that the Council should be given adequate power, for Budd went on to say that 'they looked upon the point as the very essence of a measure calculated to benefit the profession and the public, and that they would rather not have the Bill at all if this power were withdrawn.'

A second, related point was made by Dr Lankester, who pointed out that the College of Surgeons held an examination 'only applying to particular branches of the medical science; but what they contended for was, that every one taking the position of surgeon ought to have the same education as a physician; not merely to be enabled to understand the science of anatomy, but that he should have a thorough knowledge of all the branches of the healing art.'

In reply, Cowper mocked the traditional separation between the different branches of practice, apparently to the amusement of the deputation, and gave the Association the assurance that 'it was a principle of this Bill that for the future a physician should be versed in surgery as well as medicine, and vice versa.' After many years of campaigning, the general practitioners could at last see the prospect of what a correspondent of the Lancet called 'an examining board which will act on the principle that medicine and surgery are one and indivisible.'

The opponents of the Bill, however, had not been inactive; indeed we have noted that the Royal Colleges had already held a series of meetings, even before Cowper's Bill had been introduced. Following the first reading of the Bill, both Royal Colleges decided in April 1858 to petition against the Bill. Whilst the Royal Colleges were inevitably opposed to the principle of common registration for all practitioners, they appear to have been even more anxious about the powers which it was proposed to give to the central Council. As we have seen, the Council was intended to be the principal instrument for effecting the necessary reforms within
the profession and, in addition to compelling examining bodies to cooperate in conducting joint examinations, it was likely that the Council would also place other constraints on the independence of action of the Royal Colleges, the ruling bodies of which had never previously been responsible to anyone but themselves. In the petition drawn up by the College of Physicians, the College objected that it was proposed to give the Council 'not merely administrative power ... but ... power to make Orders and Regulations ... relative to the construction of Examining Boards, the assignment of their privileges, and the discipline and government of the whole profession', and the petition made it clear that the College was opposed to the establishment of 'a Council possessed of powers so extensive'. The Royal Colleges, it should be pointed out, could not legitimately claim to be opposed to the principle of centralised control of medical education and examination, for it will be recalled that the Bill which they had themselves drawn up in 1856-7 had also involved a high degree of centralisation. In the case of the corporations' own Bill, however, that centralised control was to be vested in the hands of the Royal Colleges themselves, whereas under Cowper's Bill it was to be vested in an independent body. It is important to emphasise, however, that for both the BMA and the Royal Colleges, the powers which it was proposed to give to the new Council were at the very heart of the Bill; the major difference, of course, was that whilst the BMA deputation had insisted that the Council must have those powers, the Royal Colleges were utterly opposed to the establishment of a Council with such wide-ranging powers.

It is significant that at no time do the Royal Colleges appear to have had any direct contact with Cowper after his Bill had been introduced. Cowper's lack of sympathy with many of the basic policies of the Royal Colleges was, of course, well known from his comments in earlier Parliamentary debates, and it may well have been the case that the Royal Colleges decided there was little point in trying to persuade Cowper either to drop or to amend his Bill. Instead, the Royal Colleges appear to have decided on a two-pronged strategy which involved, on the one hand, ignoring Cowper
and going direct to government ministers and, on the other hand, continuing to use Headlam as their major advocate on the floor of the House of Commons. We shall examine later the part played by Headlam but, for the moment, we shall concentrate on the more important link between the Royal Colleges and government ministers, in particular the new Home Secretary, Spencer Walpole.

As we have seen, both Royal Colleges decided in April 1858 to petition against Cowper's Bill, and by 17 April — a full month before the BMA saw the Home Secretary — a deputation from the College of Surgeons had already had an interview with Walpole. This was followed ten days later by an interview with the Prime Minister, Lord Derby. The original objective of the deputation appears to have been to try to persuade Walpole that the Government should reintroduce the corporations' Bill of the previous session, but in this they were unsuccessful. In the debate on the second reading of Cowper's Bill, Walpole indicated that the government saw this whole issue as a legislative nightmare; in explaining the government's unwillingness to bring in its own Bill, he pointed out that in the 1840s, even Sir James Graham 'with all his weight and authority in the House, and supported by one of the most powerful Governments which had been seen for years' had been unable to frame a measure acceptable to the conflicting parties. If, however, the deputation was unsuccessful in trying to persuade Walpole to reintroduce the corporations' own Bill, there is good reason to believe that it was successful in persuading him that Cowper's Bill, at least in the form in which it had been introduced, should not be supported.

On 24 April, the Lancet reported that 'The Corporations have met, and a deputation from them has waited on the Home Secretary professedly to object to Mr Cowper's measure.' The following week, the Lancet reported that the corporations had objected to the Council which Cowper's Bill proposed to establish, and went on to say that 'It is difficult to determine on what these grounds of objections rest, unless indeed upon a basis of unmitigated selfishness.' The Lancet held that the objections of the Royal Colleges were 'not, indeed, very weighty — scarcely grave enough to
merit any serious consideration’, but it went on to warn its readers that ‘they may still not be destitute of influence on the Government’.60 That they were indeed not destitute of influence is clear from subsequent events.

Long before the BMA deputation saw the Home Secretary in May 1858, Walpole had already received a deputation from the College of Surgeons, which had clearly impressed upon the Home Secretary their objections to Cowper’s Bill. It is significant, for example, that whilst Cowper and the BMA deputation appear to have been in complete agreement about the required legislative reforms, Walpole expressed doubts about two central aspects of the Bill. Thus he told the BMA deputation that objections had been raised to the principle of giving ‘all the power to a central council sitting in London’, whilst he also expressed the fear that Cowper’s Bill did not keep up ‘proper distinctions between the various classes of the medical profession’.61 In making these comments Walpole was, of course, echoing the well-known objections of the Royal Colleges.

By the time Cowper’s Bill came up for its second reading on 2 June, the situation within Parliament had once again become rather confused, for in the meantime Lord Elcho had introduced yet another Bill, whilst a third medical reform Bill had been introduced by Tom Duncombe, who had succeeded Wakley as the radical MP for Finsbury. Neither of these new Bills were acceptable to the Royal Colleges, who petitioned against both Bills.62 This was not, of course, very surprising, for the Colleges had opposed both of Elcho’s previous Bills, whilst the general flavour of Duncombe’s Bill may be roughly gauged by its title: ‘A Bill to define the rights of the members of the medical profession, and to protect the public from the abuses of medical corporations’.

The debate in the Commons on 2 June was a wide-ranging one, and involved a number of comparisons between what were held to be the advantages and disadvantages of each of the three Bills. Speaking about his own Bill, Cowper claimed that ‘Upwards of a hundred petitions had been presented to the House from members of the medical profession in favour of the Bill’, a fact which he claimed indicated that ‘the great
bulk of the profession, consisting of surgeons and apothecaries, approved of the Bill. Headlam, however, took this occasion to present to the Commons the petition against the Bill from the College of Surgeons.

The major sponsors of the other two Bills, Elcho and Duncombe, also took part in the debate, but there is no doubt that the most significant contribution was that of the Home Secretary. After reviewing the merits of the three Bills, Walpole suggested that the House should take Cowper's Bill 'as the basis of their legislation on the subject, and duly consider the details in Committee'. However, Walpole went on to say that he must ask Cowper to reconsider two points in his Bill, which were really two different aspects of the same problem: 'the one was the enormous power given to the Council, which he feared would defeat the independent action of the medical bodies; and the other was that there was no provision for keeping alive the distinct and separate action of those bodies'. The powers it was proposed to give to the Council were, said Walpole, 'too large — they were, in fact, enormous; they would be able to overrule the independent action of the Universities and the existing medical bodies'. In making this statement Walpole was, of course, quite correct, for it had been precisely Simon's intention in drawing up the Bill that the Council should have power to overrule what he saw as the 'irresponsible' Colleges and universities, and this principle was, as we have seen, fully supported by the BMA. The Home Secretary was, however, insistent; if his suggestions were accepted, he said, he should 'be glad to give every consideration to the details of them in Committee'. This was taken as an indication of Government support for a revised version of Cowper's Bill; Lord Elcho promptly withdrew his Bill, whilst the second reading of Duncombe's Bill was postponed, thus effectively ruling it out of consideration.

As a result of the Home Secretary's statement, Cowper's options had now become very limited. As an ordinary Private Member, he had virtually no chance of forcing the Bill through without the cooperation of the government. Walpole had made it clear that the price of government cooperation was the removal of the wide-ranging powers which the Bill
proposed to give to the Council, and an amendment of the Bill along these lines would, of course, have undermined one of the central objectives of the Bill.

The date for the committee stage of Cowper’s Bill was originally set for the following Tuesday, 8 June, but the committee stage was postponed on a number of occasions, and the Bill did not finally go to committee until a month later, on 6 July. A number of reformers were anxious about what might happen to the Bill in committee, for it was feared that the Royal Colleges would use their influence in order to undermine the fundamental objectives of the Bill during the committee stage. During the second reading of the Bill, for example, Lord Elcho had said that, when legislating on this issue ‘one of the chief things to be guarded against was the rendering too stringent the powers of these corporations; and he would warn the House against the efforts which those bodies would be certain to make to carry out their aim when the Bill got into Committee’. The Lancet similarly expressed the fear that when the Bill went into committee, opponents of the Bill ‘will make the most strenuous efforts to reduce the Bill to a thing of shreds and patches, and destroy all the good it contains’. As we shall see, these fears were by no means misplaced, for some important amendments which were to the advantage of the Royal Colleges were indeed made to the Bill during the committee stage. Few reformers seemed to anticipate, however, that the most important single change to the Bill would be made not in the committee stage, but before the Bill was even discussed at the committee stage, and this change in the Bill represented a major triumph for the Royal Colleges.

The long interval between the second reading of the Bill and the committee stage was used by the London corporations to exert additional pressure on the Home Secretary. It may be recalled that at the start of their campaign against the Bill, the Royal College of Surgeons had suggested that the London corporations should once again enlist the support of the Scottish and Irish corporations, and by early June, the London corporations were able to line up a powerful and impressive opposition which included representatives from virtually all the medical corporations in England, Scotland
and Ireland. A delegation representing all these corporations had a meeting with Walpole at the Home Office on 12 June. The same issue of the *Lancet* that reported this meeting also reported that the principal objection to the Bill continued to revolve around the claim that the powers of the Council were 'likely to assume a despotic character'. Like the British Medical Association, the *Lancet* had no such fears about the creation of a strong central Council. However, there is little doubt that in the period between the second reading of his Bill and the committee stage, Cowper came under strong pressure from the Home Secretary to modify his Bill in order to meet the objections of the Royal Colleges and eventually, and perhaps almost inevitably, Cowper succumbed.

On 22 June — just ten days after Walpole had received the deputation from the medical corporations, and two weeks before the Bill went into the full committee stage — Cowper introduced a number of alterations to his Bill. The most important of these changes — changes which had in effect been forced upon Cowper by the Royal Colleges, acting through the Home Secretary — related to the powers of the central Council, for clause four of the original Bill, which would have given the Council its wide-ranging powers, had now been removed in its entirety. Whereas clause four would have given the Council direct authority to define the required course of study, to compel two or more examining bodies to conduct joint examinations, and to establish its own examiners, the Council was now left with greatly reduced and only indirect authority, such as the authority to require examining bodies to provide the Council with information relating to courses and examinations.

It is worth reiterating the point that clause four was, of course, absolutely central to Simon's major objective in drafting the Bill, and the principle of a strong Council had also received the full support of the British Medical Association; indeed, it will be recalled that representatives of the Association, in their meeting with Cowper in May 1858, had said that they 'looked upon the point as the very essence' of the Bill, and that 'they would rather not have the Bill at all if this power were withdrawn'. The removal of clause four
had, in effect, removed the heart from the Bill. Moreover, there can be no doubt about the processes which led to the removal of clause four. Some years later, John Simon, who was close to government ministers throughout the whole episode, said that he had 'no doubt' that clause four was lost in consequence of the opposition of some of the existing examining bodies. Although he did not specify which bodies, it is clear that the opposition to the Bill was led and coordinated throughout by the Royal Colleges in London. Simon added that the reduction in the powers of the Council was made 'under Mr Walpole's auspices' and he went on to point out that the issue was 'never discussed in the House'. He might also have added that it was never the subject of a vote in the House. The Royal Colleges had achieved a notable success, not as the result of a public campaign, but as a result of private discussions with the Home Secretary; their victory had been achieved with a minimum of publicity and with virtually no public discussion of the issue.

In addition to removing clause four from the Bill, Cowper also made a number of other alterations, one of which — to the Bill's preamble — was symbolically important, for it recognised that, with the removal of clause four, the character of the Bill had been radically changed. The original preamble, as we noted earlier, began with the words 'Whereas it is expedient that the Qualifications of Persons seeking to enter the Medical Profession should be tested and declared by competent authorities'. Now that the Council had been stripped of most of its powers of control over the medical corporations, Cowper may well have felt — as Simon certainly felt — that the Council could no longer ensure that the qualifications of future practitioners would be tested by 'competent authorities', for Simon at least regarded the medical corporations as both incompetent and corrupt, and it was surely no mere coincidence that the whole of the first part of the original preamble was removed at the same time as clause four was removed. The revised preamble now began 'Whereas it is expedient that Persons requiring Medical Aid should be enabled to distinguish qualified from unqualified Practitioners', thus implying that the major objective
of the Bill had now become the establishment of a medical register rather than — as had been the original objective — the radical reform of the whole system of medical education and examinations through the creation of a strong central council, with the establishment of a register originally being a secondary consideration.

One other change which Cowper made was of particular significance, and this change also related to the loss of clause four. We have already seen that Cowper was opposed to the idea that, in future, practitioners should be allowed to register on the basis of a qualification in one branch of practice only, and this point was emphasised by Cowper in his meeting with the deputation from the British Medical Association. In the original Bill, this objective was to be achieved by giving the central Council the power to require examining bodies to conduct joint examinations, but this power was, of course, lost when clause four was removed from the Bill. However, at the same time that he was forced to remove clause four, Cowper also introduced a new clause — clause sixteen — which was clearly designed to make good at least some of the damage which had been done by the removal of clause four. This new clause stipulated quite simply that no person would be entitled to be registered in respect of any qualifications which he had gained after the passing of the Act 'unless he shall prove ... that his Qualifications extend both to Medicine and Surgery'. The insertion of this new clause may be seen as an attempt to salvage at least one of the educational objectives of the Bill.

By the time Cowper’s Bill came to the committee stage on 6 July it was, therefore, already a very different Bill from the one which Cowper had introduced back in March. In view of the changes which he had already made to the Bill, and in particular the removal of clause four, it is perhaps surprising that during the committee stage Cowper should have been attacked by Headlam on the ground that Cowper had ‘steadfastly refused to meet the views of those who were opposed to some parts of the Bill’.

Headlam had, of course, worked in close cooperation with the Royal Colleges for the previous eighteen months, and his attack on Cowper was a clear indication that the Royal Colleges were not yet satisfied,
Despite the amendments which had already been made, and that further amendments would be introduced during the committee stage.

Not all these amendments, it should be noted, were accepted. Thus Headlam failed to win support for an amendment to the effect that no practitioners except those who had been examined by one or other of the Royal Colleges should be permitted to register under the Bill. This was, of course, a fairly blatant attempt to create a monopoly on behalf of the Royal Colleges and, in the event, it was defeated by 138 votes to 51.²⁴

Three significant amendments to the already revised version of the Bill were, however, made during the committee stage. The most important of these amendments undoubtedly related to the complete elimination of clause sixteen, which was the new clause which Cowper had introduced at the time that he removed clause four, and which stipulated that all practitioners should, in future, be qualified in both medicine and surgery. The loss of this clause completely undermined the objective of Simon and Cowper of ensuring that in future, all practitioners would have the basic knowledge which "would render them ... competent for general practice", for it allowed practitioners to continue to register on the basis of a single qualification in only one branch of practice.

The second significant amendment related to the provision in the Bill that all registered practitioners should have the right to recover in a court of law reasonable charges for their professional attendance and advice, and for medicines supplied to patients. The College of Physicians had argued that they would 'lose caste' if such a clause were passed, and Headlam successfully introduced an amendment to the effect that any College of Physicians could pass a bye-law prohibiting their Fellows or Licentiates from bringing any such legal action, and that such a bye-law could be pleaded in bar to any such action for recovery of fees. This amendment meant, of course, that in relation to one issue about which the College of Physicians was particularly sensitive, the physicians would continue to enjoy a legal status which was quite distinct from that of all other registered practitioners.
The third amendment of note related to the composition of the central Council. The Bill had originally provided for the appointment of six independent members of the Council to be nominated by the crown, and it was expressly stipulated that these six additional members should not include any person who was a member of Council or office bearer in any of the medical corporations. This stipulation was retained in the revised version of Cowper's Bill, but removed during the committee stage; the amended clause now stated simply that four of the additional members should be appointed for England, one for Scotland, and one for Ireland.

Cowper's Bill, with these amendments, was given a third reading in the Commons on 9 July, and then had a relatively quick passage through the Lords. A few minor amendments were made to the Bill during its passage through the Lords, but none of these were of major significance for the long-term development of the profession, and the Bill finally received the Royal Assent on 2 August 1858.

Before we consider the Act as a whole, it is necessary to examine, albeit briefly, the final outcome of the negotiations relating to the composition of the central Council, for this issue was not finally resolved until some time after the Act had been passed. Although the Act did not specifically provide for general practitioner representation on the new Council, and despite the change in the clause relating to the appointment of the six independent members of the Council, the general practitioners did not give up all hope of winning some form of political representation on the General Council of Medical Education and Registration, as the new body was to be called. Thus, five days after the Bill had received the Royal Assent, the Lancet pointed out that the seventeen medical members of the General Council were to be 'chosen' by the various corporations, and it went on to say that 'This we consider to be a defect, inasmuch as from their past history, it may be assumed that the medical corporations will make the selection of members of the Council as close and irresponsible as possible. It will be for the profession to make itself felt on this point, and if the corporations are wise, they will arrange the choice on a wide basis.' A week later, the Lancet continued on the same theme, saying that 'The Act
does not determine clearly in whom the power of election of members of the Council is vested. Is it, for instance, in the case of the College of Surgeons, in the “College”, or ruling body? If the Act is to be taken literally, it is in the College itself, its Council, Fellows and Members.\textsuperscript{76} The \textit{Lancet} clearly had in mind the possibility that the representative of the College of Surgeons might be elected by the whole membership of the College, thus ensuring that rank-and-file members of the profession had some form of representation on the General Medical Council.

This issue was followed up at a public meeting of members of the College of Surgeons, which was held at the Freemasons’ Tavern in London on 5 October. Following this meeting, a letter was sent to the College Council on behalf of the members, requesting permission for a deputation representing the members to meet the Council in order to discuss the question of the election of the College’s representative to the General Medical Council. The Council’s reply was not, however, very helpful, for it simply indicated that the matter “was under consideration by this Council”.\textsuperscript{77}

On 26 October a further public meeting of practitioners was held in London, at which it was claimed that “with regard to the election of a representative from the College of Surgeons, there was no doubt at all of the right of the members to elect such representative ... The members of the College have a clear right to vote, and it will be their own fault if they do not exercise that right, and for once get a voice in the affairs of their College.”\textsuperscript{78} Following this meeting, a further letter was sent to the College Council in which it was claimed that, under clause four of the Act, the members, as part of the body corporate, were legally entitled to vote in the election of the College’s representative to the General Medical Council.\textsuperscript{79}

This letter was considered by the College Council at its meeting on 11 November. By this time, however, the Council had already taken legal advice on the matter, and this advice was to the effect that the College’s representative should be chosen by the Council alone; accordingly, J H Green was duly elected as the College representative. All claims to any democratic participation by the members in the affairs of the
College were brushed aside, and the Council decided to reply to the members' demands simply by indicating that it had already 'under legal advice elected such representative in the General Council'. The College Council had thus elected its own representative without any reference whatsoever to the members of the College; the last possible avenue for institutionalising general practitioner representation on the General Medical Council had been unambiguously closed, and the members of the College of Surgeons were still as far as they had ever been from having an effective voice in the affairs of their own College.

Having analysed in some detail the passage of the 1868 Medical Act, we are now in a position to return to the question which we posed at the end of the last chapter. The 1868 Act represented, of course, the culmination of more than thirty years' agitation for reform, but to what extent can the Act be seen as a significant triumph for the general practitioners who had been involved in this agitation? Or, to put the question another way, to what extent were the general practitioners on the one hand, and the Royal Colleges on the other, successful in shaping the Act in accordance with what they perceived to be their own interests?

In this context, it is important to emphasise that, in the form in which it was originally introduced, Cowper's Bill held out the promise of meeting most, if not all, of the longstanding grievances of the general practitioners. Thus the original Bill proposed the creation of a system which would have made it possible to ensure that in future, all practitioners would be examined in all major branches of practice, an objective which was to be achieved by the creation of a strong council which would have the power to overrule the independent action of what most general practitioners saw as the undemocratic, monopolistic and corrupt medical corporations. Both the objective of ensuring that all practitioners were examined in all branches of practice, and the means chosen to achieve this end — the creation of a council with wide-ranging powers — were very much in line with the demands of the general practitioners; indeed, in their interview with Cowper in May 1858 the deputation from the British Medical Association singled out
these two aspects of the Bill as being of particular significance. In addition, the Bill proposed to establish a system of common registration of qualified practitioners, with all practitioners enjoying the same legal status and the same legal rights.

However, the amendments made to the Bill during its passage through Parliament meant that in the end the 1858 Act met only one of the specific demands of the general practitioners. Thus the powers of the General Medical Council were considerably reduced at the insistence of the Royal Colleges and the Home Secretary, while the clause which would have required practitioners to be examined in both medicine and surgery was removed during the committee stage of the Bill. In addition, as we have seen, the general practitioners failed to win representation on the new Council. Only in relation to the one issue of common registration, therefore, can it be said that the general practitioners were successful. Even here it should be noted that common registration did not imply a common legal status for all registered practitioners; for Headlam’s successful amendment relating to the recovery of charges for professional services meant that, at least in relation to one area which it considered to be of importance, the College of Physicians had managed to ensure that the physicians would continue to enjoy a legal status which differentiated the physician from other practitioners, even within the context of a system of common registration. As far as the other demands of the general practitioners were concerned, it was to be a further twenty-eight years before the Medical Act of 1886 required all practitioners to be qualified in medicine, surgery and midwifery, thus introducing the principle of what Newman has called ‘the safe general practitioner’, and before the profession as a whole, under the same Act, was given direct representation on the General Medical Council.

If, therefore, one compares the provisions of the Bill as it was introduced into the Commons, and the provisions of the Act as it was finally passed, it is difficult to avoid the conclusion that, in the lobbying which surrounded the Bill during its passage through Parliament, the Royal Colleges were able to exert considerably more influence, and with
considerably greater success, than were the general practitioners. Thus, of all the changes which were made to the Bill, it is difficult to point to a single significant amendment which was either demanded by or specifically to the advantage of the general practitioners; indeed, all the major amendments represented a series of retreats from those principles of reform which were supported by the general practitioners, and which were enshrined in the original Bill.

Given this situation, it is not perhaps surprising that the reaction of most reformers to the Act was a relatively muted one. This is not to suggest, of course, that there was any significant group of reformers who were actually opposed to the Act, for many practitioners anticipated — quite correctly, as we shall see in the next chapter — that some of the provisions of the Act, and in particular the establishment of a medical register, would prove of considerable benefit in raising the status and financial rewards of medical practice in general, and of general practice in particular. Nevertheless, it is fair to say that the Act did relatively little to meet those specific demands which had been central to the general practitioners' campaign for reform since the 1820s, and this was recognised in much of the subsequent comment on the Act.

Thus, for example, the Lancet, whilst welcoming the Act as 'the first instalment of Medical Reform', pointed out that 'the new Act is deficient in many essential points', and that it was 'altogether inadequate to meet the difficulties which beset the subject of medical qualifications and the right of practising'. The following week, the Lancet noted that the Act 'has produced in many quarters a feeling of uneasiness, and in others those of actual disappointment'; amongst many practitioners, it said, 'a strong feeling of disappointment prevails because they have ascertained, or apprehend they have ascertained, that certain advantages which they expected would accrue, they now discover will not be conferred upon them'. George Webster, who many years previously had been the chairman of the radical London-based British Medical Association, welcomed certain provisions of the Act, and in particular the fact that the establishment of a medical register 'would afford a means of distinguishing the regular
practitioner from the impostor'. However, he went on to say that 'the new measure fell far short of the requirements of the profession', and that 'it was much to be regretted that the general practitioners were not likely to be represented in the Medical Council by members of their own body'.

If, however, the new Act failed to meet the demands of the general practitioners on a number of essential points, few reformers felt inclined to criticise Cowper and, indeed, the Lancet showed considerable understanding of the problems which he had had to face in Parliament. Thus the Lancet congratulated Cowper on the 'patient attention' which he had given to the issue of medical reform, and it recognised the great difficulties with which he had been faced 'in conciliating the parties supporting and opposing it'. Moreover, the Lancet went on to argue that 'it should be remembered, that Parliament legislated, not because it had any fancy for the subject of medical policy, but because it was absolutely nauseated and disgusted with the whole question. It was completely sickened and tired out, and allowed something to be done, which many who supported the Bill regarded as an evil, rather than encounter the annoyance of further medical agitation. Under such circumstances, it could not be expected that the enactment we have obtained would be a perfect measure, or even an approach to perfection. Whilst welcoming the fact that Parliament had, after very many years of agitation, finally passed what could only be regarded as an initial measure of medical reform, many practitioners also felt a keen sense of disappointment that the Act did little or nothing to remove some of the longstanding grievances of the general practitioners. This mixed reaction was, perhaps, most aptly summed up by George Webster in addressing a public meeting of practitioners in London on 26 October 1858: 'after many years of agitation and labour they had obtained a measure of reform which, such as it was, he felt they were bound to make the most of for the benefit of the profession and the public. They should get what they could out of the measure.'

If the reaction of most reformers was a relatively mixed one, the chief architect of the Act, John Simon, appears to have been more impressed by the Act's omissions than by its
achievements. Simon was particularly disappointed that, as a result of the opposition of the medical corporations and the Home Secretary, the newly created General Medical Council had been left with greatly reduced powers. Thus, in his evidence to a Select Committee which sat in 1878-9, Simon pointed out that ‘the Bill, as introduced, gave powers of control to the General Medical Council. Under the Act as passed those powers were not given.’ As a result, the Bill was ‘mutilated in an essential part’, and an ‘essential intention was left unfulfilled’.

Five years previously, in a memorandum, Simon had described the Council as a ‘timid experiment’, whilst in 1870 he was to declare that ‘The General Council has been a failure’. In making these comments, Simon clearly had in mind the fact that the Act had not given the Council the authority to control the actions of what he, along with many general practitioners, saw as not only deeply conservative but also corrupt medical corporations. Thus, in his presidential address to the Medical Teachers’ Association in January 1868, Simon bitterly and eloquently denounced the corporations for their ‘utter corruption’, incompetence and abuses. Although he did not refer to the General Medical Council by name, the implications of his speech concerning the Council’s inability to curb the abuses within the corporations were obvious. Simon, it is clear, was by no means happy with the way in which his Bill had been emasculated during its passage through the Commons.

As far as the Royal Colleges were concerned, it may be suggested that they had cause for quiet satisfaction with the final outcome of the legislative process. It is true, of course, that the Royal Colleges had been forced to concede the principle of common registration — something they had traditionally opposed — but it is important to note that even before Cowper introduced his Bill, the Royal College of Surgeons, if not the Royal College of Physicians, was already modifying its traditional hostility to a system of common registration, and had already accepted the fact that, given the changes which had occurred within the profession, it would not be possible to establish a system which involved separate registration for the three traditional ‘orders’ within the profession. Thus it is significant that, in the Bill which the corporations...
had themselves drawn up in 1856-7, the College of Surgeons had already conceded the principle that surgeons and apothecaries should be listed together in a single register, even though the College of Physicians, as we have seen, had insisted on a separate register for physicians. In this sense, then, it may be said that the establishment of a common register represented more of a setback for the College of Physicians than for the College of Surgeons, but even in relation to the former, it must be remembered that Headlam’s amendment relating to the recovery of fees allowed the College to retain a distinct legal status for physicians, even within the context of a system of common registration.

Moreover, there is little doubt that even if the Royal Colleges were opposed to, or at least unenthusiastic about, the principle of common registration, this was not the part of the original Bill to which they were most strongly opposed. Throughout the negotiations surrounding the Bill, both Royal Colleges saw the major threat to their privileged position as arising from the proposal to establish a central Council with wide-ranging powers. As we have seen, the Royal Colleges enjoyed a virtually unqualified success in limiting the powers of the Council. This was, of course, a major triumph for the Royal Colleges, and meant that as far as the College of Physicians was concerned, the physician would still not be required to familiarise himself with even the most elementary principles of surgery. More importantly, the limitations which had been placed on the powers of the Council meant that the Royal Colleges would continue to enjoy a very substantial measure of autonomy for, as a result of the complete elimination of clause four of the original Bill, the Council was not given powers to attack what Simon and many others saw as the abuses which had long characterised the medical corporations. Finally, it should be remembered that, notwithstanding the limitations which had been placed on its powers, the newly created General Medical Council was nevertheless an institution of major importance, for it represented the first step towards a proper system of regulating medical practice on a national level, and it is important to bear in mind that the medical corporations were amply represented on this new Council whilst the
general practitioners were left without any formal representation. In trying to gauge the extent to which the Royal Colleges had been successful in shaping the Act in accordance with their own perceived interests, it is significant to note that when, on 12 August 1858, the president of the College of Surgeons formally reported to his Council the passage of the 1858 Act, he 'congratulated the Council on the settlement, for the present at least, of the long agitated subject of medical reform'. If one recalls the almost unqualified hostility with which the Royal Colleges had greeted Cowper's original Bill, then the fact that the president of the College of Surgeons felt able to congratulate his Council on the final outcome may itself be taken as an indication of the degree to which the Royal Colleges had been successful in emasculating Cowper's original Bill.

The activities of the Royal Colleges in the eighteen months or so preceding the passage of the 1858 Act were, perhaps, most aptly characterised by two editorials which were published in the *Lancet* in 1857-8. As we have seen, the Royal Colleges had traditionally set themselves firmly against all proposals which would have introduced any radical change within the medical profession. However, by 1856, with the medical reform movement gaining ground within Parliament, it was becoming increasingly difficult for the Royal Colleges simply to deny the necessity for reform and, in 1856-7, they finally responded to the widespread demands for reform by drawing up their own Bill which was introduced into the Commons by Headlam in 1857. The *Lancet* was not, however, deceived by what appeared, at least superficially, to be a sudden conversion of the Royal Colleges to the cause of medical reform. In an editorial in January 1857, the *Lancet* said that a 'most marvellous change has come over the once anti-reforming, exclusive, and tyrannical corporations — a change marvellous in its effects, but not so from the causes which produced it. The year 1857 opens with the demand of those very corporations for reform! . . . This change has not been effected by any love of reform on the part of the corporate bodies. In heart and spirit, they have the same love of absolute power . . . which have existed from time immemorial; but the progress of public opinion has cut the
ground from beneath monopoly, and if the corporations are to exist in any efficient condition, they must go with the times. In other words, the Lancet was suggesting that reform was slowly being forced upon the Royal Colleges, and that by implication the Royal Colleges would seek to minimise the extent of that reform in an attempt to maintain their traditionally dominant position within the profession. This point was made again — but this time more explicitly — in an editorial published in May 1858, after Cowper's Bill had been given its first reading in the Commons. The Lancet argued that the objections to the Bill 'do not come from the profession at large, but emanate from selfish corporations. They know and feel that reform must come, and their anxious wish is that that reform shall be as limited as possible, so that they may retain the monopoly which they have so long enjoyed, and thus thwart any measure of a comprehensive and liberal character.' If the Lancet's observations were correct — and given the history of the Royal Colleges, one has to say that they were, at the very least, plausible — then one also has to say the Royal Colleges enjoyed considerable success in ensuring that reform, when it finally came, was 'as limited as possible' and that, as a consequence, the continued dominance of the Royal Colleges within the profession was also ensured.
PART III

The Development of Medicine as a Modern Profession
DESpite the way in which Simon's original Bill had been emasculated during its passage through Parliament, the 1858 Medical Act was nevertheless to prove of major importance for the subsequent development of the medical profession in Britain. In the first place, and despite the limitation which had been placed on the powers of the Council, the creation of the General Medical Council did represent a significant step away from the traditional system of regulating the affairs of the medical profession on a purely local level, and towards the establishment of a structure for coordinating and regulating medical education and medical practice on a national level, that is to say throughout the whole of Britain. In this respect, the reformers were to be proved correct in their assertion that the 1858 Act could only be regarded as the first instalment of reform, for subsequent measures — particularly the 1886 Medical Act, which required all future candidates to undergo an examination in medicine, surgery and midwifery — were to accelerate the process of standardising the qualifications of all medical practitioners under the central control of the General Medical Council. In the short term the Council had not been given powers to curb the abuses within the medical corporations; nevertheless in the longer term, the General Medical Council was to emerge as the lynchpin of the modern system of professional self-regulation or self-government. The detailed analysis of the subsequent development of the power and influence of the Council is, however, beyond the scope of the present work.

In the second place, whilst it would not be correct to say that the 1858 Act formally abolished the traditional tripartite professional structure — for example, the Act, unlike the
original Bill, did nothing to require all newly qualified practitioners to have passed an examination in all branches of practice — it did have the effect of further weakening the significance of the traditional divisions within the profession, in particular by the establishment of a common register for all practitioners. In this context, it is important to note that, with the exception of Headlam’s successful amendment relating to the recovery of charges by physicians, the Act did not seek to define the separate privileges of physicians, surgeons and apothecaries, as previous legislation had done, but rather to define those common privileges which all practitioners shared by virtue of being duly qualified or registered practitioners as defined in the Act. In thus emphasising those things which all practitioners shared, rather than those which had traditionally divided the profession, the Act marked a significant step in the development of a more united profession. Moreover, in giving legal definition to the term ‘qualified medical practitioner’, and in drawing a sharp differentiation between those practitioners who were qualified and therefore entitled to register under the Act, and those who were not, the Act clearly established the legal and other institutional boundaries of the regular medical profession. In this sense, we can accept Horner’s observation that the immediate effect of the 1858 Act ‘was to draw all three grades of our calling into one fold, set up a legal fence between them and the wholly unqualified, and thus bring into being a “medical profession” for the United Kingdom’.

As Horner’s comment indicates, one of the most important provisions of the 1858 Act, in terms of its significance for the subsequent development of the medical profession in Britain, was that which related to the establishment of an official register of qualified practitioners. The establishment of a register of qualified practitioners is, of course, an important process in the development of all modern professions. In view of this, the establishment of a system of medical registration and the consequences of registration are processes which merit more detailed analysis. The remainder of this chapter is, therefore, concerned with an analysis of these issues.
As previous chapters have indicated, there are many aspects of the campaign for medical reform which cannot be adequately understood without some understanding of the deeply-rooted tensions and divisions within the medical profession in the first half of the nineteenth century. It would, however, be quite wrong to convey the impression that there was no issue on which the medical profession as a whole was relatively united. There was one issue — the perceived necessity for some form of medical registration — in relation to which there was widespread agreement within the profession, even if there were important differences over the precise form which that registration should take. The establishment of a register is an important landmark in the development of any profession and, in view of this, it is not altogether surprising that the 1858 Medical Act is perhaps best remembered today not for the bitter intra-professional squabbling which preceded it, but for the fact that in establishing the General Medical Council and requiring the Council to maintain and to publish a register of qualified practitioners the Act laid down the foundations of the institutional structure of the modern medical profession.

The 1858 Act, particularly as it relates to the establishment of the General Medical Council and to the Council's duty to publish a medical register, has been the subject of a good deal of comment by both medical historians and, more recently, sociologists. In general, two rather different approaches to understanding the significance of medical registration may be identified in the literature. The first of these, which is the more traditional approach, has emphasised the benefits of registration to the public, whilst the benefits accruing either to the profession as a whole, or to particular segments of the profession, have received relatively little attention. A clear example of this approach may be found in the work of Dr Poynter, who has suggested that 'The important thing to remember is that the Act was not framed for the benefit of the profession ... but was one designed to protect the people in their individual and corporate capacity'; whilst A P Thomson, in a paper written to celebrate the centenary of the General Medical Council, has similarly argued that 'the Council came into existence for the
protection of the public'. It is, perhaps, not surprising to find this same position echoed by the General Medical Council itself. Thus in 1970, the Council pointed out that the preamble to the 1858 Act stated that it was 'expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners', and went on to argue that 'the whole of the Council's functions flow from that original objective... It can be said that the general duty of the Council is to protect the public, in particular by keeping and publishing the Register of duly qualified doctors.'

In recent years, however, this approach has been challenged by the work of a number of social scientists who have begun to develop a more sceptical analysis of the significance of registration. Thus, in their work on the medical profession in Britain, Noel and José Parry have suggested that registration may best be viewed as part of 'an occupational strategy which is chiefly directed towards the achievement of upward collective social mobility and, once achieved, it is concerned with the maintenance of superior remuneration and status'. The importance of registration, they suggest, lies in the fact that it enables practitioners to achieve 'a degree of monopoly with respect to the provision of particular types of services in the market'. Perhaps the most fully developed and detailed analysis of medical registration as a monopolisation strategy, however, is contained in J L Berlant's Profession and Monopoly, which revolves almost exclusively around an examination of the monopolistic gains associated with professionalisation. Thus Berlant sees the establishment of a medical register under the 1858 Act, together with a number of other aspects of the professionalisation of medicine, as part of a broad monopolisation strategy. The campaign for registration, he suggests, was designed to reduce competition from outside the profession, whilst the development of medical ethics — examined in detail in the next chapter — served to regulate competition within the profession.

Bearing these two contrasting perspectives in mind, in this chapter we shall examine the demands from medical men for the establishment of an official register of qualified
practitioners. On the basis of this examination, it will be suggested that the campaign for medical registration did indeed have strong monopolistic elements, and that a major thrust of medical politics in the first half of the nineteenth century was concerned with the perceived need to restrict entry into what was seen as an overcrowded profession. Thus it will be argued that medical practitioners were concerned both to control the number of qualified practitioners entering the profession and to reduce the competition from practitioners who were not qualified. It will further be argued that most practitioners were clearly aware of the effect which this process of occupational closure would be likely to have in terms of raising both the status and the incomes of medical men, and that the establishment of a medical register under the control of the General Medical Council proved to be a very effective way of restricting entry to the profession. In order to understand this point more fully, it will be useful to examine briefly what many medical men saw as the problem of overcrowding within the profession, especially from the 1830s.

In the early 1830s, the *Lancet* argued that ‘the members of the medical profession are not a body of wealthy individuals’ and, as we have seen, there is indeed considerable evidence to indicate that whilst the incomes of consultants were often very high, many general practitioners were forced to live on extremely modest incomes. The two most frequently identified causes of what medical practitioners saw as the depressed level of medical incomes were an oversupply of qualified practitioners and what was seen as unfair competition from those who were not qualified. In relation to the first point the *Lancet* held that one reason why medical incomes were depressed was because ‘the colleges are tempted by their charters to admit such a number of practitioners, that sufficient rewards cannot be afforded to them’. The evils of excessive competition, arising from an oversupply of qualified practitioners, were also pointed out by the author of an article published anonymously in the *Quarterly Review* in 1840. The author — believed to have been Sir Benjamin Brodie — argued that ‘the supply of medical practitioners is in fact not only very much beyond the demand, but very
much beyond what is necessary to ensure a just and useful
degree of competition . . . and to this cause may mainly be
attributed the present restless and uneasy state of the pro-
ession. In this, as in all other pursuits, a certain degree of
competition is required for the security of the public; but in
the medical profession it is easy to conceive that the com-
petition may be not only beyond what is really wanted, but
so great as to be actually mischievous. Moreover, the view
that the profession was overcrowded was not confined to
medical practitioners. In the debate on the second reading
of his Bill in the House of Commons in 1858, William Cowper
held that ‘at present there were more young men entering the
profession than could gain a livelihood by it’, whilst, as
Musgrove has pointed out, the term ‘overcrowded pro-
fessions’ was freely applied to both the medical and legal
professions in vocational handbooks of the period.

Such complaints about overcrowding within the pro-
ession recurred frequently in the 1830s and 1840s. One
should, of course, treat contemporary comments on over-
crowding with some caution, for such complaints are almost
as old as the professions themselves. Nevertheless, there are
grounds for thinking that, at least in this case, there may
have been some substance in these complaints; for in the
1820s and early 1830s there was a very rapid increase in the
number of persons who took out a licence to practise medi-
cine. Thus the Royal College of Surgeons estimated that in
1824 some 5000 persons held the diploma of the College;
by 1833 this number had increased to 8125, an increase of
more than 62 per cent in a ten year period. A similar story
emerges if we examine the number of medical men who took
out a licence from the Society of Apothecaries. Thus in the
five year period from 1815-16 to 1819-20, the Society
granted an average of 214 certificates per year; in the period
from 1820-1 to 1824-5, this increased to an average of 340
per year, and between 1825-6 and 1829-30 there was a
further increase to an average of 408 per year, almost double
the figure for the period from 1815 to 1820. It may well
have been the case that this rapid increase in the number of
qualified practitioners did indeed result in a degree of over-
crowding, at least for the two or three decades from the 1830s.
Peterson is in little doubt that the profession was overcrowded, for she argues that one reason why medical men, especially those in public employment and sick clubs, were so dependent on their lay employers was ‘because of the overcrowding of the profession and the consequent competition among medical men for practice wherever it could be found’. It seems probable, therefore, that the profession may have been overcrowded, and the belief that it was overcrowded was certainly widespread among contemporary medical men. Moreover, any restriction of entry to the profession could only affect medical incomes in an upward direction, and thus could only be advantageous, in a pecuniary sense, to medical practitioners. The effect of restricting entry to the medical profession had, in fact, been dealt with by no less an authority than Adam Smith, in a letter to William Cullen in 1774. Cullen, who was at that time president of the Royal College of Physicians of Edinburgh, had asked Smith for his views on the practice of some Scottish universities of selling medical degrees, often without requiring any residence. In his reply, Smith criticised those institutions for taking part in what he called ‘a most disgraceful trade’ in degrees, but he went on to point out that the ‘facility of obtaining degrees, particularly in physic, from those poor universities, ’ had two effects, both extremely advantageous to the public, but extremely disagreeable to the graduates of other universities, whose degrees had cost them much time and expense. First, it multiplied very much the number of doctors, and thereby no doubt sunk their fees, or at least hindered them from rising so very high as they otherwise would have done. Had the universities of Oxford and Cambridge been able to maintain themselves in the exclusive privilege of graduating all the doctors who could practise in England, the price of feeling a pulse might by this time have risen from two or three guineas, the price which it has now happily arrived at, to double or treble that sum . . . Secondly, it reduced a good deal the rank and dignity of a doctor. The effect of monopolistic practices on price levels was, of course, widely appreciated in the nineteenth century, and it is clear that the logic of Adam Smith’s argument was not lost on the medical profession; for by the 1840s there was a general consensus amongst medical men on the need to
restrict entry to the profession, and the issue was discussed frequently and openly in the medical journals. Thus the Lancet held that 'It is admitted on all hands that many of the evils under which the medical profession now labours, are owing to the teeming multitude of practitioners. This necessarily involves an impoverished state of the profession, and has, doubtless, contributed largely to that depression of intellect and morals among its members...The means of restraining this superfluity of doctors, and rendering the number of the profession more proportionate to the population, become, therefore, very important objects of medical legislation.' The Lancet then went on to review a number of schemes for restricting entry to the profession, including the imposition of a direct numerical limitation, a plan which was rejected as being 'incompatible with the institutions of a free country, and extremely difficult to reduce to practice under any circumstances'. Eventually, the Lancet argued that the best way to restrict entry was by 'making the standard of qualification high, as well in medicine as in letters and science'. If this scheme were adopted, 'the numbers of the profession would be effectually limited without any injurious exclusions; the character of the profession would be greatly elevated, and the public welfare would be promoted'. This was, of course, a relatively sophisticated statement of what was essentially an economic argument for restricting entry to the profession; the rather less sophisticated form of this argument was neatly expressed by a correspondent of the Lancet who pointed out, albeit rather bluntly, that 'a fair system of undisputed remuneration' depended upon 'an effective system of registration'. There can, in fact, be little doubt that one dimension of the campaign for medical registration involved a quite conscious attempt on the part of medical practitioners to restrict entry to the profession; nor can there be much doubt that practitioners were fully aware of the likely effect of this on the level of their own incomes. It is difficult to disagree with Musgrove's comment that the 'movement towards registration and the stipulation of minimum training requirements is an indication of a felt need to restrict entry' and, as we shall see later, there is some evidence to suggest that the 1858 Act met this felt need very adequately.
A second aspect of the campaign for registration which involved a clear element of monopolisation was the attempt to prevent unqualified practice, and here, once again, economic considerations were of major importance. Thus in 1843, the *Lancet* argued: ‘That “the profession is overstocked” we daily hear exclaimed, and the assertion is true. The “profession” is overstocked, and with a superabundance of unqualified men, mere speculators in drugs and chemicals.’ The result was that ‘educated practitioners are deprived of their legitimate means of obtaining a subsistence’. Medical men, continued the *Lancet*, ‘who scorn to make their liberal profession a trade, complain of this usurpation of their rightful field of profit, and of this degradation of medicine, in vain’.\(^\text{20}\) A few years later, a petition in favour of Wakley’s Bill of 1847, discussed earlier, held that ‘a very grievous injury is inflicted upon those members of an honourable profession who have complied, at a great cost, both of time and money, with the provisions of the law, and the regulations of the Colleges and Examining Boards, but who are now left without adequate protection in the exercise of their profession’.\(^\text{21}\) The view that medical education was an investment, and that unqualified practitioners were denying qualified practitioners a legitimate return on that investment was, in fact, a recurrent theme. This idea was, for example, very precisely expressed by one contributor to the *Lancet*, who held that ‘no person should risk the expenditure of time, labour, and money necessary to the attainment of his qualification or licence to practise, unless he felt himself to be effectually guarded by the laws against the competition of unlicensed and ignorant, though impudent and plausible empirics’.\(^\text{22}\)

Whilst demands for the suppression of unqualified practice were almost invariably accompanied by the claim that unqualified practitioners were taking income away from those who were qualified, these purely economic arguments were sometimes coupled with other arguments relating to the protection of the public; indeed the profession had to put forward arguments of the latter kind if it hoped to persuade the legislature to grant a monopoly of practice to those who were qualified. The contributor to the *Lancet*, cited above, argued
that if unqualified practice were made illegal, this would not only secure 'the rights and privileges of medical men', but would also serve to protect 'the public health'. The purely scientific arguments in favour of limiting practice to the qualified were not, however, very strong. Thus, as Peterson has pointed out, much of the available medical treatment was of questionable value, even by the standards of the day, whilst what little authority medical men had 'came not from their medical knowledge but had its origins in connection, social origins, or social style'. Most importantly, however, medical men themselves, as Peterson has correctly noted, 'seemed to see the issue more in terms of protection from competition than in terms of the superior claims of medical science'.

In demanding protection from competition, the rank and file of the profession was, of course, demanding what was in effect the creation of a monopoly, although most practitioners were understandably reluctant to express their demands in those exact terms. Indeed, one practitioner, the author of a series of articles published in the *Lancet* in 1841-2, explicitly attempted to defend the profession against such charges. Thus the author, D O Edwards, criticised what he called 'a belief too prevalent in society, that the medical profession are a sordid exclusive caste, who seek by vexatious barriers and invidious distinctions to secure a monopoly of the healing art'. A 'monopoly of the healing art' was, however, precisely what many rank and file members of the profession were demanding, but in relation to this issue — whether qualified practitioners should be given a legal monopoly with penalties for unqualified practice — a clear division emerged within the profession itself.

Whilst there were, doubtless, some unqualified practitioners who made a handsome living by practising amongst the middle and upper classes, there was considerable agreement amongst contemporary observers that the great majority of unqualified practitioners were practising amongst the lower classes of mid-Victorian society. Nor is this particularly surprising, for these people had the greatest difficulty in paying even the relatively modest fees of the general practitioner; as one MP observed in the debate on
Sir James Graham's bill in 1844, it was primarily the poor 'who were in the habit of asking the druggists to prescribe, in order to avoid the expense of a doctor'. As such, of course, the incomes of general practitioners were most affected by the competition of unqualified practitioners, for they were often competing for the same market amongst the ranks of both industrial workers and rural labourers. By contrast, consultants normally drew their private patients from the higher social classes, and hence their practices and incomes were considerably less affected by the activities of unqualified practitioners. Thus, to the extent that unqualified practitioners were taking income away from those who were qualified, it was the general practitioners, rather than the consultants, who suffered most.

This difference between the everyday work situations of general practitioners and consultants was of major importance in shaping the attitudes of these two groups towards the question of whether or not qualified practitioners should be given a legal monopoly of practice. Not surprisingly, the general practitioners were most vociferous in their demands for the imposition of legal penalties for unqualified practice. For example, one of the reasons why general practitioners opposed Sir James Graham's bill of 1844 was because it did not make unqualified practice illegal, and Thomas Wakley, defending as ever the interests of general practitioners, told the House of Commons that 'it was the paramount duty of that House to prevent any person from practising who was not duly qualified'.

Consultants, on the other hand, as Peterson has noted, 'had little interest in the control of unqualified practice, inasmuch as it had little effect on their positions, prestige, or practice'. They were accordingly able to adopt a less punitive attitude towards unqualified practitioners. In the article believed to have been written by Sir Benjamin Brodie published in the Quarterly Review in 1840, the author argued against giving a legal monopoly of practice to those who were qualified. The question to be decided was, he said, 'Should those who have passed their examination, and received their licence, have a monopoly of practice? Should there be penal laws to prevent their being interfered with by
the competition of the ignorant, the uneducated, and unlicensed? Or is it sufficient that the public are supplied with a list of those who are supposed to be qualified practitioners, it being then left to individuals to procure medical assistance where they please? He recognised that it was 'natural that licensed practitioners, who have expended considerable sums of money, and no small portion of their lives, in their education, should be jealous of the competition of others', and he also recognised that it was not so much consultants as 'those who belong to the class of general practitioners, that require the especial attention and protection of the legislature'. Nevertheless, he was firmly of the opinion that the profession ought not to seek legislation to suppress unqualified practice: the 'empire of opinion will do more than legislative enactments.'

Such arguments found no sympathy amongst the rank and file of the profession, some of whom pointed out in no uncertain terms the difference between their own social situation and that of consultants. Thus, referring specifically to the article in the *Quarterly Review*, one practitioner wrote that 'Court physicians and surgeons are better acquainted with the avenues of palaces than the thresholds of cottages. They are utterly ignorant of the kind of practice which is witnessed in rural districts and in poor neighbourhoods.' If they had more knowledge of such things, claimed the writer, 'they would not talk so coolly of "leaving quacks to their fate". As it is, the fate of the pretender is often much better than that of the genuine therapist.' Another correspondent of the *Lancet* pointed out, in very sarcastic tones, that the London consultants who controlled the Royal Colleges had never supported the campaign to make unqualified practice illegal: 'On this point the Colleges have never sympathized with us; they do not — they will not. They affect not to believe in the existence of the evil: Cruikshank's caricature of the well-fed flunkies lazily asking, "What are taxes?" might with equal fidelity represent two of our wealthy self-elected rulers asking one the other, "What are quacks?"'

Those practitioners — mostly general practitioners — who wished to have unqualified practice declared illegal were, however, unsuccessful, perhaps in part because the campaign
received no support from the Royal Colleges; but also because, as Cowan has pointed out, in a period in which the dominant ideology was that of *laissez-faire*, the House of Commons regarded anything which smacked of monopoly with a good deal of suspicion.\(^3\)

Thus, whilst the Medical Act of 1858 made it an offence for any person to ‘wilfully and falsely pretend to be’ a qualified or registered practitioner, it did not make unqualified practice as such illegal. The Act did, however, create a monopoly of practice for registered practitioners in all public institutions. Thus no unregistered practitioner was to be allowed to hold any appointment as a medical practitioner in the army or navy, or in ‘any Hospital, Infirmary, Dispensary, or Lying-in Hospital, not supported wholly by voluntary contributions’. In addition, unqualified practitioners were excluded from holding any appointment in ‘any Lunatic Asylum, Gaol, Penitentiary, ... Parochial or Union Workhouse or Poorhouse, Parish Union, or other public Establishment’; nor were they allowed to hold any medical appointment ‘to any Friendly or other Society for affording mutual relief in Sickness, Infirmity, or old Age, or as a Medical Officer of Health’.\(^4\)

Although many general practitioners were dissatisfied with the fact that the 1858 Act did not make unqualified practice illegal, the exclusion of unqualified practitioners from all government medical services was, in the long term, to assume greatly increased importance with the continual expansion of the public sector of health care in the late nineteenth and twentieth centuries. Thus, as Carr-Saunders and Wilson pointed out in 1933, the effect of the National Insurance Act of 1911 was to increase ‘very substantially’ the value of registration, for the 1911 Act stipulated that only registered practitioners could be accepted on the medical list.\(^5\) Moreover, although the 1858 Act did not, except in the area of government services, create a legal monopoly of practice for those who were qualified, it did impose certain disabilities on unregistered practitioners. Thus unregistered practitioners could not certify any statutory documents, and they were not entitled, as were registered practitioners, to recover at law any charges for medical services which they had rendered. In addition, as Berlant has noted, the Act also conferred an
advantage on registered practitioners 'by providing them with apparent state approval; that is, the prestige of the state was thrown behind members of the organised medical profession'.

In conferring these advantages on those who were registered, the Act followed closely the principle laid down by Sir James Graham in 1844, when he argued that the law should not be used to prohibit unqualified practice, but it should be used to 'discourage it by securing exclusive advantages to the regular practitioner'. Thus the effect of the 1858 Act was not only to exclude unregistered practitioners from the steadily expanding public sector of medical care but also, in the private sector, to give registered practitioners what Berlant has described as 'a competitive advantage in the open market'. Moreover, the competitive advantages enjoyed by registered practitioners were, like the monopoly of government service, to become increasingly important, so that the long term effect of registration was to create what became virtually a de facto if not a de jure monopoly of medical practice for registered practitioners.

If, however, these competitive advantages accruing to registered practitioners were to become more apparent with the passage of time, the impact of the 1858 Act on the level of recruitment to the profession appears to have been one which took effect almost immediately. Thus, in the twenty years or so following the passage of the Act, the growth in the number of medical practitioners in England and Wales was quite minimal, and was far outstripped by the growth of the total population. In 1861, there were 14,415 medical practitioners in England and Wales. In the decade from 1861-71, this number increased by just 269, or 1.8 per cent, and in the period from 1871-81, there was a further increase of 407, or 2.7 per cent. Thus, over the twenty year period from 1861-81, the number of medical practitioners in England and Wales increased by under 5 per cent, compared with a 24 per cent increase in the employed male population, and an increase in the total population of no less than 29 per cent over the same period.

In the two decades following the 1858 Act, there was therefore, a marked reduction in the provision of qualified medical care to the population. In 1861, there was one
medical practitioner for every 1392 persons, or 7.1 doctors per 10,000 population; by 1871 this had been reduced to one practitioner for every 1547 persons, or 6.4 doctors per 10,000 population; and by 1881 there had been a further reduction to one doctor for every 1721 persons, or 5.8 doctors per 10,000 population. It is true that in the two decades from 1881-1901 there was a considerably more rapid expansion of the profession, perhaps partly due to the fact that by the late 1870s and early 1880s there was a clearly recognised shortage of doctors; but as late as 1911 there were still fewer medical practitioners in relation to population than there had been fifty years previously. What is particularly pertinent within the context of the present discussion, however, is that a situation which was generally recognised as being characterised by a surplus of doctors prior to the 1858 Act had, within two decades of the passing of the Act, become one in which there was a serious shortage of qualified practitioners. Thus in his Carmichael Prize essay of 1879, Walter Rivington drew attention to 'the decrease in the supply of medical men', and he pointed out that William Farr, at that time superintendent of the statistical department in the Registrar General's Office, had also expressed his concern that qualified medical care had become steadily less available; indeed, Farr held that the shortage of medical practitioners was such that there was 'an imminent danger' that qualified medical care might become 'quite inaccessible to vast numbers of people'.

The shortage of qualified practitioners was also an issue which concerned the 1882 Royal Commission which had been appointed 'to Inquire into the Medical Acts'. Some of the evidence which the Commission received made it quite clear that the Lancet had not been mistaken when, many years previously, it had argued that the most effective way to restrict entry to the profession was by raising the standard of qualification. Thus although the General Medical Council had not been given power to compel the Royal Colleges to conduct joint examinations, the Council had taken action to increase the stringency of medical examinations, and this action was followed by a sharp decline in the number of entrants to the profession. In his evidence to the Commission,
Professor Humphrey, who was Professor of Anatomy at Cambridge University, noted that medical men 'had decreased in number relatively', and he agreed that there was a 'danger of the examinations becoming too strict'. He pointed out that there had been a 'greatly increasing proportion of rejections' of candidates for a licence to practise medicine, a proportion which had increased from 14 per cent in 1867 to 23 per cent in 1875. When asked directly whether he felt that 'this increasing stringency of examinations has interfered with the public interest by diminishing too much the supply of medical men', Humphry replied 'I believe it is so to some extent. When the examinations were increased, after the recommendations of the General Medical Council ... were adopted, there was a sudden diminution of members in the profession.' The link between the 1858 Medical Act and the subsequent shortage of qualified practitioners could not have been made more explicit. The Act had proved to be, as most practitioners had hoped it would, a most effective way of restricting entry to the profession.

There is some evidence to suggest that, perhaps not surprisingly, this restriction of entry to the profession was associated with a significant improvement in both the earnings and the status of medical practitioners. Thus St. Thomas's Hospital, in the evidence which it submitted to a Government Committee in 1878, pointed to the 'steady and progressive decrease of the number of medical practitioners in the United Kingdom, proportionately to the population', and went on to note that 'It is certain that within the same period the remuneration of medical men occupied in civil practice has greatly increased ... The social status and influence of civil medical practitioners has undoubtedly increased with their increased earnings.'

Systematic information on the level of incomes of medical practitioners is rather difficult to obtain, and for this reason the report of the 1878 Committee is of some importance. The Committee had been established as a result of growing concern about the declining number of recruits to the Army Medical Department and, as part of its investigation, the Committee compared conditions of work and incomes in military and in civilian medical practice. In order to estimate
the average level of incomes in civilian medical practice, the Committee invited submissions from medical schools and universities, and also from individual practitioners. Most estimates of income from civil practice showed a substantial amount of agreement and all of them further agreed that medical incomes had risen in the previous two or three decades. In the evidence which it submitted to the Committee, St. Bartholomew's Hospital estimated the average income of a country general practitioner as between £600 and £1000 per year after ten years in practice, with the incomes of general practitioners in urban areas being somewhat higher. This estimate was broadly in line with that submitted by St. Thomas's Hospital, which held that the majority of young men 'of superior education' will be found 'at the end of ten years from their entry into practice to be earning from £500 to £1500 a year, or more'. The Westminster Hospital similarly held that 'our men are very soon able to marry and earn incomes varying from £500 to £1000 a year'. Dr Hewitt from University College declined to give specific figures but, like other witnesses, he was clearly of the opinion that the financial prospects of newly qualified medical men were by this time relatively good: the 'well educated industrious student finds little difficulty in the present day in establishing himself in civil practice, and if his abilities are of an average character he is certain within a short time to obtain a tolerably good income'.

The general conclusion reached by the Committee was that 'Taken one with another, a medical man obtains in civil life a net income of £300 a year within 5 years of commencing practice. After 10 years he is unlucky if he does not net £500 a year, and thence his income gradually rises to an average of £800 to £1000. Of course, in exceptional cases these rates of income are very far exceeded'. Even if one allows for the fact that the desire of medical witnesses to encourage the government to raise military surgeons' salaries may have led them, perhaps unconsciously, to inflate their estimates of earnings in civilian practice, it is clear that the financial situation of medical men in the late nineteenth century was a steadily improving one, and one which was able to offer what Dr. Hewitt called 'a tolerably good income' for the practitioner.
of average ability, and very much more than this for the practitioner of outstanding ability.

It should be pointed out that this increased prosperity amongst medical men was not equally shared by all practitioners. As we noted in chapter three, pockets of financial hardship persisted particularly amongst practitioners who worked in the poorer urban areas until the end of the century. Nevertheless, it is clear that the financial situation of most medical men in the second half of the nineteenth century was a rapidly improving one and that, as a number of contemporary observers noted, there was a clear link between the improvement in the incomes and status of medical men and the restriction of entry to the profession which followed the passage of the 1858 Medical Act. In this sense it may be argued that the profession as a whole did indeed enjoy considerable monopolistic gains from the establishment of a medical register under the control of the General Medical Council.

In conclusion, therefore, we may suggest that those writers who have argued that the 1858 Act was passed for the benefit of the public have offered at best a grossly oversimplified account of the significance of registration, for they have ignored not only the fact that the profession derived significant monopolistic advantages from registration but equally importantly the fact that these monopolistic advantages were clearly recognised within the profession from the very beginning of the campaign for registration.
The Development of Medical Ethics in the Nineteenth Century

THE development of the general practitioners' campaign for medical reform constituted one of the more dramatic and publicly visible aspects of change within the medical profession in the first half of the nineteenth century. During this same period, however, numerous other changes were taking place within the medical profession, and many of these changes were also to play an important part in the long term development of medicine as a modern profession. One such area of change involved the development of a modern code of medical ethics.

The existence of a code of professional ethics has frequently been held to be one of the major distinguishing characteristics of modern professional occupations. If this is indeed the case, it is clearly important to examine the conditions under which a modern code of medical ethics developed in the nineteenth century. The object of this chapter is, then, to provide an analysis of the origins and early development of modern medical ethics by relating this development to other structural changes within the medical profession in the nineteenth century.

Medical ethics as such were not, of course, the creation of nineteenth century medical men; indeed, the most famous of all codes of medical ethics — the Hippocratic Oath — probably dates from as early as the fourth century BC. There was, of course, no body with the power to enforce the ethical rules contained in the Hippocratic Oath, but Leake has suggested that the oath may nevertheless have had some influence on the practice of medicine. Prior to the end of the eighteenth century, he says, 'the medical profession tried generally to handle its ethical problems on the basis of the
Greek tradition of good taste and personal honor.\textsuperscript{2} Within the present context, however, our concern is to understand the development of specifically modern codes of medical ethics, and this means that our analysis must focus not on ancient Greece, but on nineteenth century England, for it was here that the foundations of modern codes of medical ethics were laid.

Amongst medical historians, there appears to be widespread agreement that the work of the Manchester physician Thomas Percival, whose \textit{Medical Ethics} was published in 1803, marks a particularly important break point between ancient and modern codes of ethics. Thus, for example, Leake has pointed out that Percival, more than any other person, effected the "transition from the broad principles of Greek medical ethics to the current complicated system".\textsuperscript{3} This view of the significance of Percival's work is shared by most other writers on the subject. Thus Barton has suggested that Percival "compiled the first modern code of medical ethics",\textsuperscript{4} whilst McConaghey has similarly argued that the "rules of conduct of modern times stem from the small book published in 1803 by Thomas Percival".\textsuperscript{5} For Forbes, Percival's work represents a 'prominent landmark in the progress and evolution of medical ethics', and he goes on to suggest that 'No later work has modified in any material degree the precepts and practice defined by Percival for the conduct of a physician'.\textsuperscript{6}

Percival's work is, therefore, of central importance for anyone wishing to understand the development of modern medical ethics. However, whilst it is difficult to overestimate the importance of Percival's book, it would be quite wrong to see it in an almost asocial sense purely as the work of a gifted individual; for Percival's work is simply the most famous of a number of publications by medical men in the first half of the nineteenth century, all of which indicate a major concern with ethical problems in the practice of medicine. Amongst these other works one might mention in particular W O Porter's \textit{Medical Science and Ethicks},\textsuperscript{7} published in 1837, and Abraham Banks' \textit{Medical Etiquette},\textsuperscript{8} published in 1839. This concern with ethical problems also found expression in articles and editorials on medical ethics
in all the major medical periodicals, as well as in very many letters from readers dealing with similar problems. Finally, mention must be made of associations, like the Manchester Medico-Ethical Association,\(^9\) which were founded specifically to deal with ethical problems, and of the development of medico-ethical committees in medical associations founded for more general purposes, such as the British Medical Association, which established its own medico-ethical committee in 1853.\(^10\)

Clearly, therefore, Percival's concern with ethical problems in the practice of medicine was a concern which he shared with many of his contemporaries. Our problem then, is to explain why practitioners in England were so concerned with medico-ethical problems at this time. Why should so many practitioners have been concerned to set out the ethical principles which, in their view, should regulate the practice of medicine?

In general terms, the attempt to formulate codes of professional ethics and to establish institutions to enforce those codes may be seen as an attempt by professional men themselves to cope with certain recurrent problems with which they are faced in the day-to-day practice of their profession. It is important to appreciate that these problems are not individual problems, but are shared by many members of the occupational group in question. Thus, to ask why practitioners in England at this time were concerned with medical ethics is to ask what sort of problems they habitually faced in the practice of medicine. It is this question which we shall attempt to resolve in this chapter.

Before we attempt to resolve this question, it may be useful to outline briefly what has for many years been the dominant approach to understanding the development of codes of professional ethics. This approach, characteristic of the vast majority of those who have written on the subject, suggests that the development of professional ethics can only be understood within the context of an analysis of relationships between practitioners and their clients. In their classic study of the professions, first published in 1933, Carr-Saunders and Wilson argued that 'Just as the public may fail to distinguish between competent and incompetent, so it
may fail to distinguish between honourable and dishonourable practitioners. Therefore the competent and honourable practitioners are moved mutually to guarantee not only their competence but also their honour. Hence the formulation of ethical codes.  

A few years later, TH Marshall suggested that ‘Ethical codes are based on the belief that between professional and client there is a relationship of trust, and between buyer and seller there is not.’ Since the time that these words were written, the idea that an understanding of practitioner-client relationships is central to an understanding of professional ethics has become so widely accepted that it may now almost be described as a sociological orthodoxy. Characteristically, those who pursue this line of argument suggest that for a variety of reasons — primarily his ignorance — the client is unable to judge the quality of the professional services which he receives. As a result, the client is held to be very vulnerable to exploitation by the unscrupulous practitioner, and the development of professional ethics is seen as a response to this problem of social control. Thus the professional group itself undertakes to guarantee the integrity of its members by the development and enforcement of codes of professional ethics. In this way, the risk of exploitation of the client is minimised.  

Specifically in relation to medical ethics, this type of explanation appears to be accepted by most medical historians and, not surprisingly, by medical practitioners themselves.

This approach, however, has been developed without reference to any detailed empirical investigation of the development of codes of professional ethics. How well, then, does this approach enable us to understand the development of modern codes of medical ethics? Given the importance of Percival’s work in this context, it may be appropriate to begin with an examination of some of the characteristics of his book.

A careful examination of Percival’s *Medical Ethics* provides little evidence to suggest that Percival was concerned primarily with ethical problems in the doctor-patient relationship. Indeed, one of the most striking features of the book is the relatively small amount of space which he devotes to a discussion of these problems. Excluding Percival’s last chapter,
which is on medical jurisprudence rather than medical ethics, of the forty-eight remaining pages only half-a-dozen or so are devoted to a consideration of ethical problems in the doctor-patient relationship. Moreover, his advice to practitioners on how to behave towards patients is, for the most part, of a highly general kind which is very much in keeping with the Greek tradition; there is thus nothing specifically modern about it. Thus, for example, Percival advises medical practitioners to 'unite tenderness with steadiness' and 'condescension with authority'. All patients should be treated 'with attention, steadiness and humanity'. Percival gives little advice on how to cope with more specific problems in the doctor-patient relationship — although he does suggest that there should be no discussion of a case in front of the patient; that medical men should observe 'secrecy and delicacy' with female patients; and that the 'familiar and confidential intercourse, to which the faculty are admitted in their professional visits, should be used with discretion and with the most scrupulous regard to fidelity and honour'. Perhaps the most striking feature of Percival's book is that, whilst relatively little space is given to a consideration of ethical problems in doctor-patient relationships, a great deal of space is devoted to establishing a set of rules for regulating relationships between practitioners. Moreover, the advice which Percival gives to practitioners in this context is much more concrete and more detailed. Consider, for example, the following advice to practitioners concerning the proper conduct of consultations: 'In consultations on medical cases the junior physician present should deliver his opinion first, and the others in progressive order of their seniority. The same order should be observed in chirurgical cases.' Consultations involving both physicians and surgeons are slightly more complex, and Percival's advice is accordingly more detailed: 'In consultations on mixed cases, the junior surgeon should deliver his opinion first, and his brethren afterwards in succession, according to progressive seniority. The junior physician present should deliver his opinion after the senior surgeon and the other physicians in the order above prescribed.' Moreover, to resolve any uncertainty which may arise in situations where the lines of seniority are not clearly
established, Percival even sets out a method for assessing the relative seniority of the practitioners involved in the consultation.\textsuperscript{21}

The fact that Percival’s book is concerned primarily with regulating relationships between practitioners has been clearly pointed out by Leake, who makes a distinction between medical etiquette and medical ethics. Medical etiquette, he argues, ‘is concerned with the conduct of physicians toward each other, and embodies the tenets of professional courtesy. Medical ethics should be concerned with the ultimate consequences of the conduct of physicians towards their individual patients and toward society as a whole.’\textsuperscript{22} He goes on to note that “The term “medical ethics”, introduced by Percival, is really a misnomer... it refers chiefly to the rules of etiquette developed in the profession to regulate the professional contacts of its members with each other.”\textsuperscript{23} That Percival’s book deals primarily with intra-professional relationships is not very surprising, for the book was written in an attempt to resolve what was a purely intra-professional dispute. In 1789, the resources of the Manchester Infirmary were severely strained by an epidemic of either typhoid or typhus, and during the emergency the trustees of the hospital decided to double the staff. The physicians and surgeons who were already on the staff of the hospital took this as a reflection upon their efforts and resigned. In the confusion attending the change of staff, there was apparently a good deal of ill-feeling amongst the practitioners attached to the hospital; and Percival, who was physician extraordinary to the infirmary and a much respected practitioner in the area, was asked to draw up a ‘scheme of professional conduct relative to hospitals and other medical charities’. The result was a small book which was printed for private distribution in 1794, and which appeared in a revised form in 1803 as Percival’s \textit{Medical Ethics}.\textsuperscript{24} Leake has pointed out that the ‘circumstances under which Percival’s “Code” was written, made it necessary for him to place considerable emphasis on medical etiquette’,\textsuperscript{25} while Lester King has similarly observed that the book was designed ‘specifically to establish greater harmony among the physicians who had the care of the indigent sick, and was in no sense an
attempt to explore any vague ethical generalities.  

Despite the specific circumstances under which Percival was writing, his book was by no means unique in terms of the kinds of problems with which it dealt, for his concern to regulate relationships between practitioners in a more ordered fashion was clearly shared by many of his contemporaries. Thus Abraham Banks' *Medical Etiquette* was, as its title suggests, concerned almost entirely with the regulation of intra-professional relationships. Indeed, the only point at which the doctor-patient relationship becomes problematic for Banks is when one practitioner is called in to attend the patient of another, and only because more than one practitioner is involved in the management of the case. A similar story is told by the letters to the *Lancet*, in which allegations of unprofessional behaviour focus almost entirely around the conduct of consultations and the poaching by one practitioner of the patients of another. Another problem which frequently gave rise to intra-professional disputes concerned the division of fees in cases where the regular practitioner had been unable to attend a patient, and another practitioner had been called in. This problem was, in fact, the very first problem dealt with by Banks in his book, and in 1845 the *Lancet* reported that a meeting of practitioners had been arranged in London in order to establish some rules governing fee-splitting in such cases. The *Lancet* commented that 'Some general arrangements of this nature had long been needed', and it went on to express the hope that such an arrangement would help to remove 'the stigma cast upon the profession, that it displayed no more cohesion than a rope of sand'.

In fact, virtually all of the literature from this period strongly suggests that relationships between practitioners were much more sensitive and — from the profession's point of view — much more in need of regulation than were relationships between practitioners and their patients. Occasionally, those tensions between practitioners gave rise to open hostilities. Thus in 1837, the *Lancet* carried an editorial on a dispute between some medical practitioners in Newport and Monmouth. In the course of this dispute, which was publicised in the *Monmouthshire Merlin* of 25 November,
the practitioners involved took to ‘placarding’ one another, that is distributing handbills critical of their opponents.31 In 1845, the Lancet devoted another editorial to a conflict which had broken out between two medical men in Frome, Somerset. This dispute, like many others during this period, arose as a result of a consultation between two practitioners, both of whom had published pamphlets criticising the other. The Lancet observed that one of the practitioners ‘heaps insult upon insult on his opponent, on his opponent’s brother — whose part in the case was merely that of a spectator — and even attacks the entire medical profession of Frome’.32

These well-publicised conflicts merely represented the tip of the iceberg however, for conflicts between practitioners were endemic at this time, and it seems to have been appreciated by medical men themselves that the major problems with which they had to contend arose from the internal divisions and tensions within the profession. Thus Abraham Banks drew attention to the ‘prevalence of illiberality in country towns and villages; the jealousy existing between individual practitioners, who frequently, under the mask of candour and professed friendship, undermine each other’s reputation, and never lose a chance of sinking one another in public estimation, when this can be done with seeming good grace and kindness’.33 That relationships between practitioners in country towns and villages were frequently strained will come as no surprise to those who are familiar with Trollope’s description of the medical ‘war in Barsetshire’ in Doctor Thorne. Dr Fillgrave, it will be remembered, did not consider Dr Thorne ‘fit society’, and declined to meet him in consultation, following which there was a bitter exchange of letters between the two practitioners in the Barsetshire Conservative Standard, and also in the newspapers of Bristol, Exeter and Gloucester.34 Readers of George Eliot may similarly recall the hostility expressed towards the unfortunate Dr Lydgate by his fellow practitioners in Middlemarch.35 If relationships between practitioners in the provinces were frequently strained, those between practitioners in London were often characterised by even greater extremes of bitterness. As an example, one might cite the Lancet’s description of hospital
consultants and of those who controlled the Royal Colleges as 'crafty, intriguing, corrupt, avaricious, cowardly, plundering, rapacious, soul-betraying, dirty-minded BATS'. Clearly it was this kind of intra-professional conflict with which Banks was concerned; his object, he said, was 'to promote concord and harmony amongst the several branches of the profession'. A similar point had been made two years earlier by W O Porter in his _Medical Science and Ethicks_, in which he called upon all doctors to follow the golden rule: 'Do unto all men as you would that they should do unto you'. He hoped that we 'should not then be exposed to feel, or witness, or even hear of those feuds, which sometimes arise between members of the profession, so injurious to the interests of all concerned, and so derogatory to that high character, which it is our duty to preserve, and should be our chief aim to raise in the estimation of the public'.

This same point was repeated again and again by those writing on medical ethics. Thus in 1845, a correspondent of the _Lancet_ called for the introduction of 'a standard or rule to guide doctors in their professional activities'. However, he went on in a somewhat despondent manner: 'Or, is this subject too delicate, and must we continue to live on, hoping for better feelings and deportment in those who have hardly a fair word to use for their brother? Perhaps it is doubtful, after all, whether any set of rules would unite a body so disaffected as ours.' Perhaps most telling, however, are the comments of the author of an article on medical ethics published in the _London Medical Gazette_. The author, W B Kesteven, pointed to the 'urgent need of a generally acknowledged principle whereon to base the rules of medical ethics', and claimed that 'it is doubtless the want of some such principle that permits the jealousies, bickerings, and calumnies which distress and divide the different branches and interests of the profession'. He then went on to ask, 'Is it not an unenviable paradoxical notoriety, that a profession pre-eminently benevolent and ... eleemosynary to all beyond its own immediate sphere, should towards its own members be proverbially uncharitable and litigious? Alas! will the time never be that men shall apply to its members the eulogium so unwittingly extorted from the
pagans of old, "See how these Christians love one another?"
Or rather, how long shall it be that the world shall continue
to say, "See how these doctors hate one another?"

This argument is particularly telling, not least because it
draws attention to the fact that relationships between doctors
and the wider society, including patients, were frequently
characterised by benevolence and charity on the part of
practitioners. The same point was made in an editorial in
the *Lancet* in 1842 and, indeed, this seems to have been
something in relation to which the medical profession took
considerable pride. The everyday problems facing medical
practitioners, it is clear, arose not in their relationships with
their patients, but in their relationships with their professiona
colleagues, relationships which all too frequently were char-
acterised by tensions, hostilities, accusations and counter-
accusations. The development of medical ethics, it is sug-
gested, can best be understood as an attempt to regulate
these tension-ridden relationships so as to reduce the amount
of potentially very damaging intra-professional conflict.

There appear to have been two major processes associated
with this endemic conflict within the medical profession,
and both of these processes found a clear and direct expression
in the literature on medical ethics during this period. The
first of these processes related, perhaps not surprisingly, to
the tensions associated with the breakdown of the traditional
tripartite professional structure, which has already been
analysed in earlier chapters. Building upon this earlier
analysis, we are now in a position to draw out the relation-
ship between these changes within the structure of the pro-
fession and the development of codes of medical ethics.

As we have already seen, in the first half of the nineteenth
century the traditional tripartite structure of the profession
was steadily breaking down. We have also seen, however,
that an institutional structure appropriate to the newly
emerging professional differentiation was slow in developing,
for whilst medical men were increasingly being divided into
consulting and general practitioners, the institutional struc-
ture of the profession continued to reflect the more
traditional differentiation between physicians, surgeons and
apothecaries. This resulted in a very confused situation, in
which the definitions of appropriate roles and relative statuses within the medical profession became very unclear. As a correspondent of the *Lancet* pointed out in 1841, ‘Everything connected with our profession is, at present, in a state of disorder and uncertainty; its laws are in abeyance; and young men, about to commence their medical studies, are quite at a loss what to expect, or what plan of education to pursue.’ The medical profession in the first half of the nineteenth century was, as Leake has bluntly but accurately characterised it, ‘a mess’, and within this fluid and ambiguous situation, different types of practitioners ‘jockeyed for positions of prestige and power’.

This jockeying for position was related largely to the prevailing confusion surrounding the division of labour within the profession, a problem which, as we have seen, was intimately related to the different statuses attributed to different kinds of medical work. Thus whilst more and more medical men were combining the practice of medicine, surgery, midwifery and pharmacy, the old established elite groups within the profession did everything in their power to maintain a clear separation between the work of the physician, the surgeon and the apothecary, and to stigmatise the work of the general practitioner. The sort of intra-professional hostilities which arose at the local level within this situation are well portrayed in George Eliot’s *Middlemarch*, a novel which is of some significance to medical historians since, as Harvey has noted, it delineates ‘with historical precision the emergence of a new kind of doctor’, the general practitioner. Harvey correctly points out that Lydgate ‘represents this new type and the hostility he arouses in the physicians of Middlemarch . . . reflects in large part that uneasy awareness that the traditional orders, jealously guarded, are being subverted.’ One might add that this ‘subversion’ of the ‘traditional orders’ was also an important factor underlying the conflict between Dr Thorne and Dr Fillgrave so graphically described by Trollope.

In many ways, the local conflicts portrayed in *Middlemarch* and in *Doctor Thorne* may be seen as microcosms of the developing conflict on the national level. The attempt on the part of the Royal Colleges to maintain the traditional divisions
within the profession and to stem the rise of the general practitioner gave rise to a long struggle for medical reform which was bitterly fought on both sides, and which gave rise to extremes of vituperation and personal insult, in which the Lancet in particular excelled. In 1858, the Westminster Review not inaccurately described the history of the medical reform movement as a history of 'the irreconcilable divisions and quarrels of the profession itself', whilst two years previously, the same journal had referred to 'the dissensions which have so long festered' within the medical profession.

The widely held picture of a profession as a harmonious community is not one which can readily be applied to the medical profession in the first half of the nineteenth century; indeed, as Poynter has noted, the medical profession during this period was 'a profession in chaos ... split from top to bottom by jealous rivalries and competing interests'.

This analysis provides a major key to understanding why relationships between practitioners were so frequently characterised by ill feeling and disharmony. It also helps us to understand why the problem of defining what kinds of medical work should be undertaken by what kinds of practitioners figured prominently in the literature on medical ethics, for this issue constituted a major source of the intra-professional disputes which so bitterly divided the profession during this period. Thus only in these terms, it is suggested, can we properly understand Percival's lengthy discussion of the relationships which, in his view, ought to prevail between the different 'grades' of practitioners. Of Percival's three chapters on medical ethics, the whole of the third chapter is devoted to a discussion 'Of the Conduct of Physicians towards Apothecaries', whilst other statements on the relationships between physicians, surgeons, and apothecaries are scattered liberally throughout his work. In his advice on the conduct of mixed consultations, cited earlier, Percival showed a clear understanding of the nice status distinctions between physicians and surgeons in his recommendation that the most junior physician present should deliver his opinion after the most senior surgeon had delivered his.

On issues of this kind, Percival was a conservative — according to Sir George Clark, 'the best conservative opinion' of his
— and accordingly he advised his fellow practitioners to maintain the traditional division of labour within the profession. Thus in his chapter on hospitals, he advised, 'A proper discrimination being established, in all hospitals between the medical and chirurgical cases, it should be faithfully adhered to by the physicians and surgeons on the admission of patients.' Similarly, in the chapter on private practice, he recommended that 'in large and opulent towns the distinction between the provinces of physic and surgery should be steadily maintained. This distinction is sanctioned both by reason and experience.... Experience has fully evinced the benefits of the discrimination recommended, which is established in every well regulated hospital, and is thus expressly authorised by the faculty themselves and by those who have the best opportunities of judging of the proper application of the healing art. No physician or surgeon, therefore, should adopt more than one denomination, or assume any rank or privileges different from those of his order.' Similarly, in his chapter on the relationships between physicians and apothecaries, he suggests that physicians should refuse a request to visit the patients of an apothecary in the latter's absence: 'Physicians are the only proper substitutes for physicians; surgeons for surgeons; and apothecaries for apothecaries.' Thus Percival tried to present clear guidelines which would prevent the continual disputes over the division of labour within the profession; his solution, as we have seen, was to call for the maintenance of the traditional divisions within the profession.

While most practitioners seem to have agreed that the breakdown of the traditional tripartite division of labour was a major cause of the jealousies and tensions within the profession, few were willing to accept Percival's conservative remedy. The radical position was most clearly set out in a long paper on medical ethics by Thomas Laycock, which was published anonymously in the *British and Foreign Medico-Chirurgical Review* in 1848. Laycock pointed out that the profession 'seems little better than a chaos; the whole mass is upheaving; decomposition and recomposition are going on; but we can discern no great principles by which coherence and strength may be given to the discordant elements. It is
quite impossible that the intelligent lay public will notice the professional desire for organisation and legislation, so long as the impelling motives are nothing more dignified than sectional interests, grade prejudices, or interested clamours in a pecuniary sense. ‘How,’ he added, ‘can members of Parliament and the educated classes esteem a profession, the members of which mutually disparage each other?’ Laycock then went on to examine the squabbles over the division of labour within the profession.

All bodies of men are intolerant of any departure from principles and practices that have become conventional. Although such departure may have nothing whatever in it morally wrong, yet it is visited ‘with the utmost rigour of the law’ — that may have been conventionally established. Thus physicians fully engaged in practice will bitterly regard the young physician who, feeling the pressure of the *res augusta domi*, may exercise any surgical talent he may possess, or who, suspecting that his medicamina are not well compounded, or of a spurious quality, may look to the manufacture of his powder, or point his own guns.

He pointed out that even though all types of practitioners cooperated harmoniously in voluntary organisations like the Royal Medico-Chirurgical Society, the medical corporations continued to ‘raise their Shibboleth before the public, before Parliament, and in the profession, and establish their differences where there is hardly any distinction’. Many surgeons treated medical cases as frequently as surgical ones. ‘To all purposes, and in every way, the surgeon is a physician, with the ability to operate chirurgically superadded to his medical acquirements, and is conventionally permitted to operate, prescribe, and receive his fee, so long as he calls himself “surgeon”. But let him add MD to his name, and convention­alism forthwith binds up his right hand, severs him from his College, and circumscribes the sphere of his usefulness.’ Laycock added that ‘if it could be proved that this line of demarcation, already obliterated in the voluntary associations, is of any use whatever to either the profession or the public when drawn between two classes of practitioners, in which
the difference of education and attainments is now at least really but nominal, we would acquiesce at once in the arrangement. But it has yet to be shown that a union of these two educational institutions, and a reorganisation on a broad base of ethical principles, would either render the surgeon less skillful, or the physician less educated or intellectual. The whole matter is indeed hardly capable of serious argument.' Laycock thus called for the abolition of those professional divisions which Percival had defended in 1803. Only by taking such a step, argued Laycock, could the intra-professional squabbling and bickering be ended. Thus he concluded his paper by calling on enlightened practitioners to place the organisation of the profession on 'its proper basis', or else the profession would remain 'as it is—a chaos of conflicting elements'.

Shortly afterwards, the Lancet gave Laycock's paper its 'warmest approbation'. Quoting extensively from the article, the Lancet said 'there are no passages in the article...with which we more cordially agree than those which describe the unworthy jealousies which rise between some among the different classes of the profession, when any man dares step out of his proper line; when the physician or surgeon, for instance, trenches upon the province of the general practitioner; when the general practitioner aspires to the work of the surgeon or physician; or when the physician and surgeon dare to defy artificial distinctions, and pass from one department to the other'. The Lancet added 'how constantly have we dealt on the meretricious separation, the unworthy caste-division, which seeks to make the highest surgeon lower than the physician, and the highest general practitioner lower than both'. Since its foundation in 1823 the Lancet had, of course, campaigned consistently for the abolition of the tripartite professional structure, and by the middle of the nineteenth century there was widespread agreement amongst doctors that there could be no end to the disharmony and tensions within the profession as long as the tripartite structure remained. It is hardly surprising that this issue should have figured prominently in the literature on medical ethics.

These tensions, which were associated with structural
changes within the profession, were further exacerbated by the fact that, at least for much of the first half of the nineteenth century, medical men were involved in intensely competitive relationships with their fellow practitioners. In the early part of the century, this high level of competition between practitioners appears to have been associated with the fact that there was a rapid increase in the number of practitioners qualifying in the 1820s and 1830s, and, as we have seen, this may well have resulted in an overcrowded profession. This overcrowding, in turn, gave rise to a situation in which cut-throat competition between rival practitioners, particularly in the form of poaching of each other’s patients, was common. Indeed, competition between local practitioners was so intense that many practitioners ‘feared, and rightly, that they would lose patients to their competitors if they left town for a holiday’; as a result, some medical men never went away for more than a weekend during much of their professional lives.§

Highly competitive relationships of this kind not infrequently gave rise to disputes between practitioners serving similar or overlapping neighbourhoods. Such disputes, especially those involving allegations relating to the poaching of patients, were particularly likely to occur in situations where two practitioners were involved in treating the same patient; for example, in situations where one practitioner was called to attend the patient of another practitioner in the latter’s absence, or where a second practitioner was called in for a consultation at the patient’s bedside. As we shall see, the attempt to establish a set of guidelines which would have the effect of reducing the potential level of conflict between practitioners in such delicate situations constituted a second major concern of those writing on medical ethics at this time.

Before, however, we examine the relevant guidelines laid down by Percival and others, it is important to note that this high level of competition between practitioners cannot be wholly explained simply in terms of overcrowding within the profession for, important though this was — at least in the first half of the nineteenth century — there was a second aspect to this problem of competition between practitioners.
This arose from the fact that the two major roles within the profession — that of the general practitioner and of the consultant — were both, in a real sense, new roles; and as such they had not yet become as clearly differentiated and institutionalised as they are today. In particular, there was one critical area of overlap between the role of the consultant and the role of the general practitioner, an area of overlap which not only differentiates the nineteenth-century consultant from the present-day consultant, but which was also at the root of much of the conflict and competition which characterised consultations between practitioners in the nineteenth century.

This critical area of overlap arose because consultants did not then — as they do now — confine their practice to consulting work but, as we indicated earlier, they also normally acted as general practitioners to small numbers of wealthy clients. In addition, there was a considerable number of practitioners — particularly in the provinces, where consulting work was normally less readily available — who derived the major part of their income from general practice, but who also occasionally acted as consultants within their own locality. The result was that consultations were normally held between two practitioners, both of whom to some extent were in general practice; there was thus a real element of competition involved, particularly for wealthier clients. Within this situation, mutual suspicion and hostility between consultants and general practitioners were common. Allegations by general practitioners that consultants were trying to steal their patients either by calling on the patient a second time without the knowledge of the regular attendant, or by implicitly or explicitly criticising the treatment prescribed by the latter, were common. From the 1830s onwards, the *Lancet* published numerous letters from practitioners alleging unprofessional conduct on the part of other practitioners, the most common complaints being those which related to the conduct of consultations and the poaching of patients. In a paper on medical ethics published in 1849, W B Kesteven referred to the 'censurable condemnation of a professional brother, whether of a higher or lower grade, by looks, gestures, innuendos, etc. For example, a physician called in
consultation takes occasion in the absence of the general practitioner to hint that a different treatment should have been adopted; or by indirect means, such as friendly visits, etc., supplants the ordinary attendant, or destroys his patient's confidence'. In 1854, the Association Medical Journal, in reply to a correspondent who complained of the conduct of a consultant, agreed that it was easy for a consultant to:

Convey a censure in a frown,
And wink a reputation down.

The Association Medical Journal went on to point out that 'extreme watchfulness and honesty of act and feeling are essential requisites in this class of practitioners'.

Given the potentiality for conflict inherent in the structure of consultations at this time, it is not surprising that a number of writers, from Percival onwards, should have seen the conduct of consultations and the poaching of patients as particularly problematic areas requiring regulation by a code of medical ethics. Percival's advice on these matters is quite detailed. Thus he recommends that punctuality should be observed by both parties to the consultation, and that 'No visits should be made but in concert, or by mutual agreement'. When consultations are held, 'no rivalship or jealousy should be indulged. Candour, probity and all due respect should be exercised towards the physician or surgeon first engaged.' 'Officious interference, in a case under the charge of another, should be carefully avoided.' If a practitioner is called to a patient under the care of another practitioner, he should always observe 'the utmost delicacy towards the interest and character of the professional gentleman, previously connected with the family'. The practitioner should 'interfere no farther than is absolutely necessary with the general plan of the treatment; to assume no further direction, unless it be expressly desired; and, in this case, to request an immediate consultation with the practitioner antecedently employed'. Abraham Banks deals with many similar problems, advising consultants not to call on patients in the absence of the general practitioner, giving advice on how to divide the fee when a consultation
is held, on how to act when a second party is called in to decide upon the treatment of another practitioner, and on what to do in a situation in which one practitioner is called to attend the patient of another practitioner. The fact that such situations were regarded as particularly delicate is further indicated by the fact that in W Fraser's 'Queries in medical ethics', a series of questions and answers on ethical problems published in the London Medical Gazette in 1849, no less than fourteen of the twenty-seven queries related specifically to problems which were associated either with consultations, or with taking over the management of a case from another practitioner.

In summarising the argument thus far, we may say that the development of a code of medical ethics did not represent the outcome of any special interest on the part of medical men in the formulation of abstract philosophical principles; indeed, the probability is that medical men were no more given to abstract philosophical speculation than was any other section of the educated classes. Rather, the growing concern of medical men with ethical problems has to be seen as a practical concern which arose from and represented an attempt to resolve certain recurrent problems with which they were faced in the day-to-day practice of their profession. Moreover, the foregoing analysis has suggested that these practical problems arose primarily within the context of relationships between practitioners, partly as a result of the highly competitive nature of these relationships, and partly as a result of other structural tensions within the profession.

It is clear that this analysis of the development of medical ethics stands in sharp contrast to the commonly held view that medical ethics developed primarily in order to regulate relationships between practitioners and their patients; as we have seen, such a view finds little support from an analysis of nineteenth-century writings on medical ethics, in which ethical problems within the doctor-patient relationship occupy only a minor place. This is not to suggest, of course, that an understanding of practitioner-patient relationships is irrelevant to an understanding of the development of medical ethics, for there are some passages in the work of Percival and other writers which do relate to the doctor-
patient relationship. What is suggested is that the significance of the doctor-patient relationship for an understanding of medical ethics has hitherto been considerably overemphasised, and that the development of medical ethics may be much more closely related to the need — widely perceived amongst nineteenth-century medical men — to regulate relationships between practitioners in such a way as to reduce what was felt to be the excessive and potentially damaging level of intra-professional conflict and competition.

The above argument — that the development of a code of medical ethics may be seen as a response to the perceived need to control intra-professional conflict and competition — may be taken as providing partial support for Berlant’s view, mentioned in the previous chapter, that a code of ethics functions as an anti-competitive device which is consistent with a broader strategy of monopolisation on the part of the medical profession. It should be emphasised, however, that the argument in this chapter provides only limited support for Berlant’s view. Thus whilst it has been argued that the development of medical ethics was indeed associated with a perceived need to restrict competition amongst medical men, it has been argued this development was also a response to other tensions within the profession which reflected other much deeper and more far-reaching changes within the structure of the profession, and that these other changes, which involved a radical redefinition of the roles and statuses of medical men, cannot be adequately conceptualised simply in terms of an increase in the level of competition within the profession. While the analysis in this chapter is consistent with Berlant’s analysis, it also suggests that Berlant’s exclusive concentration on the anti-competitive functions of medical ethics can provide only a partial and one-sided understanding of the development of medical ethics.

Moreover, it is also important to remember that, while nineteenth-century codes of ethics did indeed contain many statements of an anti-competitive kind, it should not be assumed that the development of a code of ethics automatically has an immediate or dramatic impact in terms of restricting the actual level of competition between prac-
titioners and, indeed, such an assumption would not appear to be justified at least for the first half of the nineteenth century. Thus what is of importance is not simply the degree to which a code of ethics is elaborated, but also the extent to which that code is respected by, and enforced within, the profession as a whole. In this context, one might note that the frequency with which medico-ethical problems were raised in the medical literature of the early nineteenth century is not only an expression of the growing awareness of ethical problems on the part of many practitioners, but it is also an expression of the fact that what some practitioners were coming to regard as the rules governing 'proper' professional conduct continued to be disregarded by many practitioners.

In this respect, those who sought to impose what they saw as 'higher' standards of professional conduct were faced with two major problems. The first of these problems related to the difficulty of persuading medical men to act 'ethically' in a situation in which, as a result of overcrowding within the profession, they were constrained to compete with their fellow practitioners, sometimes in a quite ruthless fashion, simply in order to secure an adequate income for themselves and their families. In this sense, Peterson is undoubtedly correct, at least in relation to the first half of the nineteenth century, when she suggests that 'too many medical men in an overcrowded profession had to choose economic survival above loyalty to their peer group'. Thus it is suggested that one reason why these developing codes of ethics appear to have had only a limited influence on the behaviour of medical men in the first half of the century was that other structural constraints led them to act in a highly competitive manner towards neighbouring practitioners. Indeed, it may be argued that, rather than the development of a code of ethics leading to a dramatic reduction in the level of competition between practitioners, it was a reduction in the actual level of competition between practitioners in the second half of the century which facilitated the more general acceptance of certain principles of 'ethical' behaviour within the profession; for within the context of a less competitive market for their services, medical men were no
longer constrained to outbid or to undercut their colleagues in the way in which they had formerly been. As we saw in the previous chapter, following the 1858 Medical Act the profession was able very effectively to restrict entry to the profession, and there is little doubt that this had the effect of greatly reducing the level of competition between practitioners. The 1858 Act must thus be regarded as a development of major significance in helping to bring about those conditions which were conducive to the much more widespread acceptance of an agreed code of 'ethical' behaviour amongst all sections of the profession in the second half of the nineteenth century.

The second problem which faced these practitioners who sought to develop a code of medical ethics was the fact that, throughout this period, the only sanctions which they could use against those who broke the rules of this code were moral sanctions; for there was, of course, no single body which had any effective power to discipline practitioners for 'unprofessional' conduct. Again, this situation changed dramatically following the passage of the 1858 Medical Act, for the Act gave the General Medical Council formal powers to discipline practitioners and, as a final resort, to remove from the Medical Register the name of any practitioner who was judged by the Council to have been guilty of 'infamous Conduct in any professional Respect'. After 1858, therefore, the adherence to certain basic principles in the conduct of one's practice was no longer something which was dependent on the voluntary acceptance of those principles by each individual practitioner, for increasingly minimum standards of professional behaviour were not only defined, but also enforced, by a central body which had legally defined powers to discipline those practitioners whose behaviour, in its view, fell below those minimum standards.

In conclusion, it would be wrong to suggest that the work of writers such as Percival had an immediate impact on the behaviour of most practitioners, for the process of developing and enforcing a code of ethics was long and gradual and required, amongst other things, the development of a less competitive structure of relationships between practitioners and a new professional institution with the
power to enforce those rules. If these conditions were not met in the first half of the nineteenth century, they were increasingly met in the second half, so that by the end of the century one could speak in meaningful terms about the way in which the behaviour of medical men was limited and controlled by a code of ethics. The medical profession, in other words, was finally beginning to develop an effective system of self-discipline.
THROUGHOUT this book, the term 'medical profession' has been used to describe all those persons who held a formal qualification of whatever kind to practise medicine. This use of the term 'profession' is, of course, both convenient and conventional, but it does tend to mask the significance of the major changes which occurred in the organisation of medical practice in the course of the nineteenth century. For this reason, it is important to remind ourselves that, in the early nineteenth century, those who made a living by the provision of medical care — even those who were qualified — not only exhibited few of the characteristics which we have come to associate with modern professions but, equally importantly, they did not even constitute a single occupational group. In 1800, as we have seen, qualified medical care was available from members of three quite distinct and separately organised occupational groups, each of these occupational groups being sharply differentiated from the others in terms of the legal status of its members and in terms of the education and training which they had received. By 1900, however, these traditional divisions within the profession had lost most of their former relevance, and the medical profession had emerged as a single, relatively united, relatively homogeneous occupational group, at least in terms of the common pattern of basic medical education which had been prescribed for all practitioners by the 1886 Medical Act and of a common legal status for all registered practitioners. Moreover, during the same period in which medical practitioners were beginning to form a single, clearly differentiated occupational group, many other changes — some of the more important of which have been described in previous chapters —
were also taking place within medicine. As a result of these changes, the medical profession had, by the end of the nineteenth century, begun to emerge in something like the form in which we know it today, at least in terms of the institutional structure of the profession. In this sense, it may be argued that it was in the nineteenth century — and more particularly in the second half of the nineteenth century — that medicine emerged as a modern profession.

But in what precisely did this process of professionalisation consist? Amongst the many changes which occurred within the medical profession in the nineteenth century, is it possible to identify some more general process under which many of these particular changes may be subsumed? What, in other words, do we mean when we refer to the emergence of medicine as a modern profession?

In the last decade or so, sociologists have come increasingly to focus their attention on the fact that professional occupations are characterised by a high degree of autonomy from lay control. This emphasis derived initially from the work of Eliot Freidson, whose Sorokin Award winning book *Profession of Medicine* has since come to be widely regarded as the standard work on the sociology of the medical profession. In his work, Freidson argued that it is precisely this high degree of professional autonomy or self-regulation — or what, in a different context, he calls ‘professional dominance’ — which is the distinguishing characteristic of modern professional occupations. Thus the strategic distinction between the professions and other occupations is held to lie in ‘legitimate, organized autonomy — that a profession is distinct from other occupations in that it has been given the right to control its own work’. In terms of this perspective, it is clear that any analysis of the development of medicine as a modern profession must include, as a major part of that analysis, an examination of the development of medical autonomy or, to put it slightly differently, it must include an analysis of the development of medical men’s authority and control over their work, their patients, and the organisation of their professional lives.

Bearing these comments in mind, the significance of many of the developments examined in previous chapters becomes
immediately apparent. Thus, in terms of the professionalisation of medicine, the significance of the establishment of the General Medical Council lay not merely in the fact that the Council was given certain powers to regulate medical practice throughout Britain but, more particularly, in the fact that the membership of the Council was itself dominated by the medical profession. Thus in effect it was the profession itself, acting through the General Medical Council, which was entrusted with the task of maintaining a medical register, just as it was the profession itself which was given the power to stipulate the minimum requirements, in terms of training and education, for admission to the register.

Similarly, the attempts to define a code of medical ethics in the first half of the nineteenth century represented the first tentative steps towards the establishment of a system of social control in which the professional activities of medical men would be regulated by the actions and sentiments of their professional colleagues. As we have seen, in the first half of the century, these efforts met with what one can only describe as, at best, very limited success. However, in the second half of the century, the enforcement of a code of ethics became increasingly effective, partly because relationships between practitioners during this period became less competitive as a consequence of the restriction of entry to the profession, and partly because the General Medical Council, under the 1858 Act, was given formal powers to discipline those members of the profession who were found guilty of unprofessional conduct.

All of these developments — the establishment of the General Medical Council and of a medical register, the stipulation of minimum standards of education and training, the restriction of entry to the profession, and the elaboration and enforcement of codes of medical ethics — may thus be seen as important parts of that process through which all major aspects of the practice of medicine came increasingly to be regulated by the profession itself. The establishment of a system of self-regulation of this kind, relatively free from lay control, lies at the very heart of the professionalisation process.

The analysis contained in previous chapters indicates quite
clearly that this process of professionalisation cannot be adequately understood without reference to the conscious efforts of medical men themselves to create new professional institutions and to raise the status of their occupation. As Norbert Elias has observed, if we examine processes of professional development, we come face to face 'with people struggling ... to adjust their inherited institutional framework with all its incongruities to what they feel to be their own needs'. In medicine as in other professions, these struggles for institutional reform were of major importance for the development of the profession, for it was within this context of struggle that the modern medical profession began to emerge.

It would nevertheless be quite wrong to suggest that the development of the modern medical profession can be understood simply in terms of changes within the profession itself, for, to a considerable extent, the rise of the medical profession was also dependent on changes within the wider structure of society — changes over which medical men themselves had little or no control — which provided the social structural conditions favourable to the emergence not only of medicine, but also of many other occupations, as modern professions. In order to understand the process of professionalisation more fully, therefore, it is necessary to examine in a little more detail the relationship between processes of change in the wider structure of society and changes within the structure of the profession itself. The object of this final chapter is to examine the interrelationship between two such processes which, it is held, were central to the development of the modern medical profession. The two processes with which we shall be concerned are, firstly, the development of a relatively high level of professional autonomy on the part of medical men and, secondly, the growth of the market for medical care in the nineteenth century. The latter process, it will be argued, had important implications for the development of the medical profession, particularly in so far as it helped to bring about conditions which were conducive to the emancipation of medical men from a variety of forms of lay control of medical practice.

Thus it will be suggested that the development of medical
authority and control cannot be adequately understood without reference to the changing structure of the market for medical care in the late eighteenth and nineteenth centuries; indeed, it will be argued that the growth of the market for medical care was, as Paul Starr has put it, 'one of the main currents deep beneath the changing structure of medical institutions'. In this final chapter we shall, therefore, take a fairly long term view of the professionalisation process, and we shall be concerned specifically with an analysis of some of the major changes in the structure of the market for medical care from the late eighteenth century, and with some of the ways in which these changes within the market for medical care facilitated the development of a high level of professional autonomy.

On a general level, it is reasonable to suggest that one of the major constraints operating on the producers of any product is the structure of the market for that product. In view of this, it is perhaps somewhat surprising that so little work has been done on the structure of the market for medical care during the late eighteenth and nineteenth centuries, for as Starr has pointed out, 'the economic history of medicine, especially before the twentieth century, remains almost entirely to be written'. Unfortunately, information on the structure of the market for medical care in the late eighteenth century is relatively scarce, but nevertheless a number of general points can be made with a reasonable degree of certainty. The first of these is that, throughout the eighteenth century, the provision of qualified medical care was relatively unimportant as an economic activity, for medicine did not then constitute the major industry which it has subsequently become in all industrialised societies. Thus Elliott has pointed out that the 'pre-industrial professions handled areas of life involving potential social problems and conflicts but their specific contributions to the economy . . . were marginal'; whilst Freidson has drawn attention to the fact that prior to the nineteenth century the services of qualified medical men were used by only a relatively small section of the population, for a variety of alternative sources of care were not only freely available, but in many cases were probably also more consistent with
the indigenous belief systems of most ordinary people. Thus at the time when John Heysham was apprenticed to a country doctor in the latter half of the eighteenth century, the regular practitioner had 'much less of the confidence of the public than the itinerant quack. At all times he had to compete with the village blacksmith, the barber, and the herbalist, whose “culling of simples”... impressed the vulgar mind with uncommon faith'. Freidson is almost certainly correct when he notes that 'Official medicine... had only a loose, variable connection with the general cultural beliefs of the population. The bulk of everyday consultation of healers by the general population was not controlled by the organised medical occupation.' Indeed, it is important to bear in mind that most care of the sick was not even part of the market economy, for it took place within the context of familial and neighbourhood relationships which were outside the realm of market exchange.

Although it is difficult to make any very precise estimate of the size and structure of the market for qualified health care in the eighteenth century, it is clear that that market — like the market for other specialised professional services — was a relatively small one, and also that the demand for qualified medical care tended to be relatively highly concentrated amongst the wealthier sections of the community. Thus Reader has pointed out that, in the eighteenth century, most of the population simply could not afford qualified medical care, whilst Franklin has similarly noted that most people in the predominantly rural society of eighteenth-century England were 'not in the habit of calling in a doctor in times of illness. A few medical men settled in the local country and market towns and visited the richer inhabitants of the neighbourhood but the ordinary villager and agricultural worker could not afford to employ them. Old wives’ tales, traditional herbal recipes, or charms, were the mainstay of the sick.'

Moreover, it should not be assumed that even those who could afford to pay for the services of qualified practitioners necessarily chose to use those services on a regular basis, for throughout the eighteenth century the traditions of domestic and folk medicine remained very strong, whilst the use of
unqualified practitioners was also very common, and, as Turner has pointed out, even the highest status groups regularly patronised unqualified healers. Evidence from eighteenth-century diaries also suggests that, even amongst relatively affluent and well educated groups, the services of unqualified practitioners or the use of domestic or folk remedies were frequently preferred to the services of qualified medical men. Thus it seems that qualified medical men were by no means assured of a very stable or secure market for their services, even amongst those sections of the population which could afford qualified care.

It is important to emphasise, however, that in pre-industrial England — as in virtually all other pre-industrial societies — very many people were simply unable to afford the services of qualified practitioners. For those in the poorer sections of society, domestic care and folk medicine, perhaps supplemented by the help and advice of friends, neighbours or local lay healers, represented the only realistically available forms of health care. Thus it may be suggested that throughout the eighteenth century the market for qualified medical care was limited both by the inability of large sections of the population to pay for qualified medical care, and also by the persistence of traditional attitudes towards health and health care which continued to emphasise the importance of alternative sources of care over that provided by qualified practitioners.

It is of some interest to note, if only in passing, that the structure of the market for medical care outlined above was by no means unique to pre-industrial England, for it would seem that a relatively low level of effective demand for qualified medical care was — and indeed still is — a characteristic of pre-industrial societies generally, including the pre-industrial societies of eighteenth-century Europe and North America. It is significant, for example, that in describing the situation in late-eighteenth and early-nineteenth-century America, Starr has drawn attention to the relatively small size of the market for medical care, and has argued that the 'fundamental constraint on medicine in early American society was the relatively low level of demand for medical services, rather than any institutionalised restrictions on
Claudine Herzlich has similarly drawn attention to the 'absence of a real medical market' in France in the late-eighteenth and early-nineteenth centuries\textsuperscript{16} whilst Jean-Pierre Goubert, in a careful analysis of medical practice in France around 1780, emphasises not only the relatively small size of the market for qualified health care, but also the extent to which this demand was concentrated in what he calls 'the social elite'.\textsuperscript{17}

It may be argued that there was a third major characteristic of the market for medical care during this period. This related to the fact that, throughout the eighteenth century, there was no real national market for medical care, but rather a series of loosely connected, more or less independent, local markets; again, this would seem to be a common characteristic of pre-industrial societies, in which the centralisation of government and administration and the integration of the society on a national level are — at least by modern standards — still relatively undeveloped. In England, the extent to which the organisation of medical practice continued to reflect the traditional orientation towards local markets rather than a national market may be seen in the purely local, guild-like structure of the medical corporations, for throughout the eighteenth century, there was no genuinely national organisation with either the inclination or the ability to control entry to the profession or, indeed, to regulate medical practice in any way. Instead, there was a large number of purely local licensing bodies, each of which was concerned only with the regulation of one particular branch of practice in its own locality.

Thus even the most prestigious of the licensing bodies in England, the Royal College of Physicians, was originally founded simply to control the practice of medicine in London and an area of seven miles around the capital. It is true, of course, that shortly afterwards the formal powers of the College were extended to cover the whole of England, but the College showed virtually no interest in exercising these broader powers and, instead, continued to concern itself almost entirely with maintaining the exclusive status of a small group of elite practitioners in London. Thus, as the official historian of the College has pointed out, through-
out the eighteenth century the College 'showed no interest whatever' in regulating medical practice outside of the capital. One indication of the extent to which the College was concerned almost exclusively with the London market is provided by the fact that, until 1783, the College's Catalogue, containing the names of those who held a licence from the College, listed only those who held a licence to practise in London; the names of those who held a licence to practise outside of London were simply omitted from the list. It is equally significant that, as late as 1800, the College listed 153 practitioners whom it had licensed to practise in London, whilst it listed only twenty-six physicians who were licensed to practise in the whole of the rest of the country. Indeed, it was not until the 1840s that the number of extra-licentiates — that is, those who held a licence to practise outside of London — began to show any significant increase, and it is not until the middle decades of the nineteenth century at the very earliest that the College can be regarded as having made any real contribution to the provision of medical care outside of London.

Like the physicians, the surgeons and apothecaries also continued to be organised, throughout the eighteenth century, in local guild-like organisations. Thus until 1745 the surgeons were united with the barbers in the Company of Barber-Surgeons, which was one of the City of London Livery Companies and it was not until the Royal College of Surgeons was founded in 1800 that all connections between the surgeons and the City of London were formally severed. Even then it was significant that the full title of the new College was the Royal College of Surgeons of London; it was not until the College received a new Charter in the mid-1840s that the 'London' was changed to 'England' in a belated recognition of the fact that the College, by this time, had become involved in supplying practitioners for a national market rather than a purely local one.

The third group of practitioners — the apothecaries — were similarly organised in what was a local society, for throughout the eighteenth century, the Society of Apothecaries merely had the power to regulate its members resident in London. It was only with the passing of the
Apothecaries’ Act of 1815 that the Society assumed the responsibility for licensing practitioners on a national level.

Outside the capital, medical practice was very partially regulated through a variety of local institutions which included the final remnants of ecclesiastical control through bishops’ licences, to the local Barber-Surgeons’ Companies which persisted into the eighteenth century in some of the more important urban centres, including Bristol, Norwich, Chester, Newcastle and York. In Scotland the situation was broadly similar, for here too there were no national licensing bodies, but rather a variety of institutions each of which exercised limited powers within its locality. Thus it may be suggested that insofar as the medical profession was organised at all during this period, its organisation reflected an orientation towards local markets rather than an orientation towards a single, national market.

Perhaps the clearest single indication of this fact is that, for the greater part of the eighteenth century, there was no national register of medical practitioners, the first such register being The Medical Register for the Year 1779 published anonymously by Dr Samuel Foart Simmons. Moreover, this register was a ‘purely private and unofficial venture’, and doubtless it was also very incomplete. Nevertheless, the publication of Simmons’ register was a significant development, for the register made available for the first time relatively reliable information relating to the total number of practitioners and their distribution on a national level. As Sir George Clarke has put it, ‘at long last in medical affairs the discovery of England was completed. It had become possible to know approximately how many members of each professional branch were in practice, and where. Vague speculations as to whether they were too few or too many in the country generally or in any particular region could now give way to calculations based on facts.’ In this case, Clark is quite correct to describe Simmons’ register as ‘a landmark in the history of the profession’, for the publication of a national register — even a very imperfect one — may be taken as an early indication of a growing awareness of the fact that the focus of the medical market was steadily shifting from the local to the national level.
In summarising the argument thus far, we may say that throughout the eighteenth century the major characteristics of the market — or more precisely the markets — for medical care were that the level of effective demand for qualified care was both relatively low and relatively highly concentrated in the higher social strata, and also that these markets were local rather than national in character. We must now examine some of the implications of this market structure for the development of medicine as an occupation.

As we noted earlier, Starr has suggested that the 'fundamental constraint on medicine' in pre-industrial America was the relatively low level of demand for qualified medical care, and he goes on to note that 'Whether it was because of popular preference for domestic care and disbelief in the value of professional medicine, or the difficulty of obtaining and affording treatment, or the ease with which competitors entered the field, many physicians found it extremely difficult to support themselves solely from medical practice... Starting out in practice frequently meant protracted under-employment and hardship.'

Starr's comments are, of course, made specifically in relation to the situation in pre-industrial America, but they could with equal accuracy be applied to the situation in eighteenth century England; for here, too, the low level of demand for qualified health care meant that for many practitioners medical practice on its own did not offer a stable, permanent or indeed full-time career. Thus a number of eighteenth-century practitioners are known to have left the profession after failing to secure an adequate income from medical practice, whilst many more practitioners — probably a majority — were forced to supplement their income from medical practice with a second source of income.

A few practitioners, of course, were fortunate enough to have benefactors who were prepared to supplement their modest income from medical practice. One such practitioner was Mark Akenside, a friend of Doctor Samuel Johnson who, according to Dr Johnson, 'never attained any great extent of practice' despite the fact that he 'placed himself in view by all the common methods'. Johnson further tells us that, particularly in his early years of practice, Akenside...
would perhaps have been reduced to great exigencies' had he been forced to live on his medical income alone. Fortunately for Akenside, however, he was saved from such exigencies by the generosity of an old friend, one Mr Dyson, who allowed him three hundred pounds a year.

Those practitioners whose medical incomes were inadequate and who could not rely on such help from family or friends were forced to find a different method of supplementing their medical earnings, and the practice of having a second occupation in addition to medicine seems to have been a common one throughout the eighteenth century. Thus, during the period in which they tried, without success, to establish themselves in medical practice, both Oliver Goldsmith and Tobias Smollett accepted literary commissions in order to increase their total incomes. Goldsmith, for example, found that he was able to make only 'a threadbare existence' from medical practice, and it was during this period that he accepted a number of literary commissions, for 'though writing might not provide a respectable income of itself, it could serve to supplement the slender living which Goldsmith was making as a physician'. Smollett made not one, but two, equally unsuccessful attempts to establish himself as a medical man. Though Smollett, like Goldsmith, eventually achieved fame as a novelist, it is important to note that originally Smollett 'did not aspire to write novels but to practise medicine', and it was only as it became clear that he could not support himself from his medical earnings that he gradually resorted to writing for a living. The practitioner to whom George Crabbe was apprenticed in 1768 similarly 'had more occupations than one', for in addition to his practice as a country surgeon, he also ran a farm.

There is little doubt, however, that the most usual method of supplementing a purely medical income was that which involved combining the role of a medical practitioner with that of a retail trader. Thus throughout the eighteenth century, many medical men continued to adopt a very traditional and very broad conception of the doctor's role which included not merely the dispensing and the sale of drugs, but also the keeping of an open shop in which was
sold a whole variety of goods, some of which were more closely related to the role of a retail trader than to that of a medical practitioner. The lower branches of the profession, of course, had very strong historical links with certain aspects of the retail trade, and it is clear that those links remained strong throughout the eighteenth century. Thus in 1753, an advertisement announcing the sale of an apothecary’s shop in Hampshire listed, along with the medical utensils, ‘some good Tobacco and a Tobacco Engine’. Similarly, the stock of James Shergold, an apothecary who practised at Salisbury in Wiltshire, included tea, chocolate, spirituous liquors and tobacco. This involvement in the retail trade was particularly common — indeed, it was almost certainly normal practice — amongst the lower branches of the profession, but it was by no means unknown even amongst the elevated ranks of the physicians. Claver Morris, a physician who practised at Wells in Somerset in the eighteenth century, made his own cosmetics which he sold to his patients, including ‘hair butter’ and face and eye lotion, whilst in addition he also supplied one client regularly with scented snuff.

It seems probable that these secondary sources of income slowly became less important towards the turn of the nineteenth century. In his analysis of provincial medical practice in England during this period, Kett has suggested that a growing number of apothecaries were ‘leaving their shops and acquiring ... a view of themselves as distinctly medical practitioners’. Elsewhere in the same paper he has noted that the surgeon-apothecary was beginning to develop ‘an idea of the requirements he would have to fulfill as a full-time medical practitioner’. The emergence of medicine as a full-time occupation was, however, a very gradual process; as Thackeray’s portrait of John Pendennis suggests, and as other evidence confirms, the combination of medical practice and retail trade persisted until well into the nineteenth century.

From what has been said, it is clear that throughout the eighteenth century medical practice on its own frequently provided only a very unstable and insecure method of earning a living. This point is of considerable importance. As long as medical men were unable to support themselves from medical practice alone and therefore had to have a second source of
income, medicine was severely limited not merely in terms of its development as a profession but at a much more basic level in terms of its development as a full-time, specialised occupation. During the nineteenth century, of course, medicine did emerge as a highly specialised, full-time occupation: medical men lost not only their shopkeeping functions and their other secondary occupations but also, with the development of new specialised occupational groups such as pharmacists, those functions, such as the dispensing of drugs, which were ancillary to medical practice. However, this process of occupational specialisation — a process which is, of course, the basic prerequisite for the emergence of modern professional occupations — could only develop within the context of a large and growing market for health care which made it possible for medical practitioners to support themselves and their families on the basis of medical practice alone, without the necessity to supplement a medical income by engaging in other, non-medical activities. Thus it may be argued that, for as long as the level of demand for qualified care was relatively low (as was the case throughout the eighteenth century), medicine was severely limited in terms of its development into the relatively secure, specialised and full-time occupation which it was later to become.

It is important to remind ourselves, therefore, that throughout the eighteenth century, medicine not only had few of the characteristics which we associate with modern professions but that, even more basically, it was frequently not even a full-time occupation. Moreover, it is interesting to note that this was by no means a peculiar characteristic of medical practice in England, for a similar situation existed in other societies in the eighteenth and early-nineteenth centuries. Thus, in describing the situation in New England in the early-nineteenth century, Riznik has pointed out that 'most physicians were involved in a self-sufficient economy which was generally unable to support professional men ... at anything more than a low standard of living', as a consequence, 'perhaps the majority of New England physicians ... made up income deficiencies by farming and supplying their own needs'. Similarly, Claudine Herzlich has argued that in late-eighteenth and early-nineteenth century France,
the low level of demand for medical care meant that many practitioners had only a small clientele, whilst the fees they were able to charge 'were often very low and insufficient for earning a living'. That this was certainly the case for at least some French practitioners is confirmed by the recently discovered account book and journal of Thomas Hérier, which provide unusually detailed information about the practice and finances of a country surgeon at the end of the eighteenth century. Lemay's analysis of Hérier's income from medical practice throughout the whole of his thirty-two year career as a medical man suggests that 'no matter how devoted to his profession he was, Hérier could not support a family on these earnings'. Indeed it is significant that when, after seventeen years in practice, Hérier went to register the death of one of his children, his occupation was listed as 'cultivateur' or farmer, a fact which, as Lemay notes, 'shows the importance of what appeared to be his chief livelihood in the eyes of the parish priest'.

In the Netherlands in the eighteenth century, it was also a common practice for medical men to supplement their earnings from medical practice by engaging in a variety of second occupations, including those of barber, innkeeper, fisherman, bailiff, schoolmaster and secretary in local government, whilst other practitioners were employed in the law courts and in the beer trade. Thus not only in England, but probably in most societies in the eighteenth century, the relatively small size of the market for health care may be seen as a major constraint on the development of medicine as a full-time, specialised occupation.

Thus far it has been argued that the relatively low level of demand for qualified health care throughout the eighteenth century made it difficult for many practitioners to make a reasonable living from medical practice on its own. It would, however, be quite wrong to convey the impression that all practitioners faced similar difficulties in this respect. Thus we have already noted that during this period there was a marked tendency for the demand for health care to be concentrated amongst the highest social strata, and those practitioners who were fortunate enough to find favour amongst the aristocracy and gentry themselves enjoyed relatively high
status and incomes as a result of their association with a high status clientele. However, whilst this group of practitioners was able to enjoy the lifestyle appropriate to eighteenth-century gentlemen, their involvement in the network of face-to-face relationships which constituted the patronage system also placed severe constraints on the development of professional autonomy. Thus, as a number of writers have noted, the patronage relationship was typically associated not with a structure of colleague control, but with a structure of client control, for within the patronage system the aristocratic and wealthy client was the dominant figure in the doctor-patient relationship. This point has, perhaps, been most forcefully made by Holloway, who noted that, by virtue of the wider social bases of his power, the client was in a position to define both his own needs and the manner in which those needs were to be met. As a consequence, 'the patient, not the doctor, determined the conditions on which service was rendered', whilst the doctor, 'faced by powerful, wealthy, critical, demanding, and ill-informed patients was forced into the role of lackey and mere comforter'.

Elements of Holloway's analysis may be found in the work of a number of writers, but perhaps the most detailed and systematic analysis of the significance of the patronage system in eighteenth-century medicine is contained in the work of Jewson. Jewson points out that throughout the eighteenth century medical men were dependent upon the favour of a small group of upper class patients who had the ability to make or break the career of any individual practitioner. Aristocratic patients, he points out, 'were in a position to choose for themselves the most satisfactory or amusing practitioners from among the host of medical men who clamoured for their favours. It was the patient who judged the competence of the physician and the suitability of the therapy. The wealthy and influential threw their support behind whichever practitioner pleased them and withdrew it from those in whom they were disappointed. Thus it was the client who held ultimate control in the consultative relationship'.

Jewson goes on to argue that this dependence of medical men on their lay patrons had important implications for the
form and content of medical knowledge in the eighteenth century. He suggests that, in a situation in which the client held ultimate power in the consultative relationship, physicians 'had no choice but to tailor their theories and remedies to meet the expectations and requirements of their genteel patients' whilst 'upper class patients were able ... to direct the development of medical knowledge by shifting their patronage from one group of innovators to another'. More specifically, Jewson suggests that what are generally recognised as the distinctive characteristics of eighteenth-century medical knowledge — an orientation towards symptoms rather than aetiology, a monistic pathology, and an absence of any sharp differentiation between afflictions of the body and of the mind — may be related to the constraints placed upon practitioners in a situation in which the careers of medical men were under lay rather than professional control, and in which practitioners were forced to compete with each other for the favours of a small group of wealthy and influential patients. Thus, in relation to the first of these characteristics — the orientation towards symptoms rather than aetiological processes — he suggests that

One of the most important manifestations of the patient's power over the practitioner was his ability to dictate the very definition of illness itself. In particular, the patient's understandable desire to be cured of his symptoms, rather than diagnosed of his disease, had an indelible impact on contemporary theories of nosology and pathology. Medical knowledge revolved around the problems of the prognosis and therapy of symptoms, rather than the diagnosis and analysis of diseases. Symptoms were not regarded as the secondary signs of internal pathological events, but rather as the disease itself.

The attention paid by medical practitioners to psychosomatic conditions such as hypochondriasis illustrates the point: 'When the wealthy and powerful chose to identify emotional stress with disease, practitioners accepted their definition of the situation and acted as if such maladies were real pathological entities. The symptom based nosology of the eighteenth century was thus a reflection of a patient domin-
ated medical system. On a more general level, it may be suggested that the development of professional autonomy was severely restricted under the patronage system, for both the problems requiring solution and the terms in which an acceptable solution was defined were determined by criteria established not by the profession, but by the patient. The picture which emerges of medicine during this period is not, then, a picture of medicine as a highly autonomous profession, but rather that of an occupational group whose members were highly dependent on their lay patrons. As we shall see later, it was only with the structural changes in medical practice which occurred during the nineteenth century that doctors finally achieved a position of dominance within the consultative relationship, and it was only then that the emphasis in medical research began to move away from those problems of prime concern to the patient — that is, problems of therapy — towards the more basic scientific problems involved in the diagnosis and analysis of disease. The relatively high level of intellectual detachment of the nineteenth-century medical scientist was thus, at least in part, a function of his growing social detachment from the patient.

Jewson’s analysis brings out very clearly the fact that the patronage system was typically associated with a network of highly particularistic relationships between medical practitioners and their upper class patients. Thus wealthy and influential clients were in a position to demand personal attention and the practitioner — if he wished to make a success of his career — was constrained to orientate his behaviour towards the particular needs of each individual patient. A similar point has also been made by a number of other writers. Thus, in their classic study of the professions, Carr-Saunders and Wilson pointed out that the ties which bound the practitioner to his patron or patrons were those of loyalty and personal subservience, and they went on to note that such ties of personal dependence severely limit the development of professional consciousness and professional autonomy. More recently, Johnson has also drawn attention to the fact that patronage is associated with a fragmented, locally oriented occupational group,
where the individual practitioner defers to and identifies with his patron or patrons rather than with his professional colleagues. Under these conditions, he notes, the sense of occupational community remains relatively undeveloped, whilst the authority of the patron reduces the possibility of developing professionally imposed forms of social control, such as those which are involved in the development and enforcement of codes of professional ethics.\textsuperscript{52}

Johnson's contribution, in particular, draws attention to the way in which an orientation towards local markets tends to fragment an occupational group by cutting practitioners off from their colleagues practising in other localities. Thus the patronage system has the effect of integrating practitioners into a network of relationships with clients at the local level and at the same time inhibiting the development of a network of relationships with colleagues at the national level. It is reasonable to suggest that this fragmentation of the profession into a large number of small, relatively isolated groups of practitioners was one of the processes which inhibited the development of a common professional consciousness or any real sense of professional 'community' in the eighteenth century. Quite clearly, a fragmented occupational group of this kind is unlikely to be able to develop its own internally imposed controls on the behaviour of its members and, indeed, under these conditions, the members of an occupational group are much more likely to orientate their behaviour towards the expectations of their clients rather than those of their colleagues. Thus as Freidson has pointed out, the more the everyday work setting of a practitioner integrates him into a network of relationships with professional colleagues, and the more the career structure of the individual is determined by the evaluation of his colleagues, the greater are the constraints on the practitioner to orientate his behaviour towards the expectations of his professional peers. In contrast, the practitioner whose work situation isolates him from his colleagues is much less subject to any form of intra-professional control. However, as Freidson goes on to point out, to the extent that a practitioner becomes less dependent on his professional colleagues, he also becomes more dependent on his clients, for it is
they, rather than his colleagues, who are able to determine the practitioner's occupational success or failure.⁵³

Freidson's framework is an extremely useful one in the sense that the structure of medical practice in the eighteenth century provides a particularly clear-cut example of what he calls 'client-dependent' as opposed to 'colleague-dependent' medical practice.⁵⁴ Thus, as we have hinted above, throughout the eighteenth century there was nothing resembling a 'professional community' of medical men in any real sense, not even — except in very rare cases — at the local level. There was, for example, no regular medical press on a secure footing until the Lancet began publication in 1823, whilst, as we have seen, a code of medical ethics governing professional behaviour was not highly elaborated, and certainly not effectively enforced, until considerably later. At the local level there were few medical societies prior to the end of the eighteenth century,⁵⁵ while the fact that medical men were involved in a highly competitive market in which there was a limited demand for their services meant that relationships between practitioners were all too frequently characterised not by cooperation, but by intense rivalry and mutual hostility. As Porter has pointed out, in the eighteenth century the structure of professional practice was such that it 'did not tend to breed binding corporate professionalism . . . Upward mobility was individual rather than collective. It was no-holds-barred in the clamour for advancement.⁵⁶

It is clear that in such a situation it was impossible for the profession to develop centralised, universalistic standards of either clinical or ethical behaviour independent of the particularistic customs and traditions of the local community; that this was so is clearly indicated by what, to a modern observer, appears to be the very 'low' standard of professional behaviour characteristic of many eighteenth-century medical men. Thus the intensely competitive relationships, the frequent public disputes and the patented inventions, and the many forms of conspicuous self-advertisement which were characteristic of medical life during this period would all, by today's standards, be regarded as highly improper and unprofessional forms of behaviour. It would, however, be quite inappropriate to judge these forms of behaviour by
today's standards, for they simply reflect the fact that the eighteenth century practitioner perceived — quite accurately — that, in terms of his own career, it was more important to please his clients than to please his colleagues. Moreover, such forms of 'unprofessional' behaviour could only be eliminated as medical men became increasingly emancipated from lay control, and as medical career structures came increasingly under the control of the profession itself. This process, as we shall see, was associated with the growth of the market for medical care in the nineteenth century, and with the development of professional control of this enlarged market. It is to these issues that we must now turn.

In England, the growth of demand for qualified health care in the nineteenth century appears to have been closely associated with the development of an increasingly complex, urban industrial society. As the College of Physicians itself noted, 'The enlarged and improved state of society ... has ... much extended the demand for medical advice. Families which in a former condition of the Kingdom were either necessitated or content to apply for the relief of their indispositions to domestic medicine have recourse in these days of refinement and opulence to practitioners of physic.'

In particular, it was the growth of a sizeable middle class which provided the basis for the rapid development of the medical profession in the nineteenth century, for as Holloway has noted, 'the rise of the middle classes produced a prosperous, numerous and expanding clientele', especially for those practitioners who were willing to provide their services at more moderate rates than those traditionally charged by the 'consultant' physician and surgeon. That it was possible for practitioners to offer their services at moderate rates was, at least in part, a function of the process of urbanisation which concentrated the clientele of the medical practitioner within a comparatively small area and thus facilitated a reduction in both travelling time and in the working expenses of the doctor's practice. In addition, certain innovations within the profession — notably the sliding scale of fees, which was increasingly adopted in the nineteenth century — also helped to reduce the cost of medical care to families living on relatively modest incomes,
and thus had the effect of further widening the market for the services of the qualified practitioner.

Before we examine some of the more important implications of this changing market structure for the development of the medical profession, it may be appropriate to examine, if only briefly, some of the processes which lay behind this growth of demand. Anyone who is familiar with the history of medicine in the nineteenth century will not have failed to notice that this growth in the demand for medical care coincided with the development of an increasingly scientific basis for medical practice, and it is therefore tempting to suggest that this higher level of demand may have been a reflection of the improved effectiveness of scientific medicine. To assert the existence of such a simple relationship would, however, be extremely misleading; as numerous writers have pointed out, these improvements in medical science, whilst very real, did not immediately translate into significant therapeutic advances in medical practice; indeed, there is little evidence to suggest any dramatic improvements in the effectiveness of medical care until the early part of the twentieth century. It is therefore important to note that, as Starr has pointed out, the 'increased demand for medical services seems to have preceded significant improvements in the effectiveness of physicians'. If, therefore, we wish to understand those processes which led to the growth in demand for medical care, we must look elsewhere.

In part, of course, the expansion of demand for health care may simply have reflected the fact that in an increasingly prosperous society, an increasing number of people were able to afford specialised professional services, such as those provided by medical practitioners. However, it is reasonable to suggest that the increased demand for health care may also have been associated with changing attitudes towards health and disease in the nineteenth century. Holloway, writing about Victorian England, has hypothesised that, at least amongst the middle classes, the widespread belief in progress and in the rational control of the world was extended to include the idea that man could control disease in much the same way that he was so busily controlling other natural forces. Similarly, he has suggested that the emphasis on
individual achievement which was such a marked feature of Victorian middle-class belief systems necessarily placed a high premium on the maintenance of health, for good health came increasingly to be seen 'both as a prerequisite for success and as a necessary condition for the enjoyment and exploitation of success'.

In addition it may be suggested that the increasingly close association between medicine and science was also of major importance for, as Larson has pointed out, during this period science was coming to be seen as the 'cardinal system of cognitive validation and legitimation'. In other words, although the increasingly scientific basis of medical practice had no immediate or dramatic impact in terms of therapeutic effectiveness, nevertheless the cultural status of science almost certainly lent prestige and authority to medical men, and may well have been a significant process in increasing the level of demand for their services.

The immediately preceding arguments are, of course, somewhat speculative, for the processes which lay behind the expansion of demand for health care in the nineteenth century were extremely complex and by no means fully understood. However, although we may not yet fully understand these complex processes, it is clear that the development of a large and growing market for health care on a national level had important implications for the development of the medical profession.

In the first place, the growth in demand — in purely quantitative terms — meant that in the course of the nineteenth century, medicine came to offer an increasingly stable and rewarding long term career, and this in turn was probably important both in terms of attracting recruits of a higher social status, and in terms of building up a sense of commitment to the profession on the part of those who had chosen a medical career. As we saw in chapter seven, in the second half of the century — and particularly after the profession had secured a significant degree of market control by restricting entry to the profession — the increasingly secure market situation of medical men was reflected in a significant increase in medical incomes.

It should be noted, however, that it was not simply the
growth of the market in purely quantitative terms which was important; equally important was the fact that as the market grew, it altered both the total amount of demand and the pattern of demand, by bringing into the market for health care many clients whose socio-economic status was relatively modest. One consequence of this process was that patronage became an increasingly atypical form of the doctor-patient relationship as the demand for medical care ceased to be concentrated in the higher status groups. Thus, by the mid-nineteenth century, the doctor-patient relationship was typically no longer one in which the practitioner faced a wealthy and influential patron, but one in which the status of the patient was comparable to or lower than that of the doctor. Moreover, the fact that the doctor increasingly earned his living not by treating a small number of patients for relatively high fees, but by treating large numbers of patients for relatively modest fees, inevitably served to reduce the doctor's dependence on any particular patient. Under the patronage system, to incur the displeasure of an influential patient could, as Jewson has pointed out, have disastrous consequences for a practitioner's career; to incur the displeasure of a ledger-clerk, who was just one of several hundred patients, would hardly be likely to have the same sort of consequences. As numerous studies have indicated, the relative status of doctor and patient within the wider society is always an important element in structuring the doctor-patient relationship, and there can be little doubt that the change in their relative statuses in the nineteenth century was an important part of that process whereby the balance of power shifted away from the patient and towards the doctor.

The most dramatic illustration of the consequences of a change in the relative statuses of doctor and patient is undoubtedly to be seen in the context of the development of charitable hospitals for meeting the medical needs of the poor in the late eighteenth and early nineteenth centuries. Hospitals of this kind were, of course, developed in many Western societies during this period, and wherever such hospitals were developed — in Britain, in France, in Vienna and in the United States — the fact that relatively high status
practitioners were treating low status patients resulted in a dramatic reversal of the balance of power within the doctor-patient relationship. Thus doctors were — perhaps for the first time — in a position to ignore the wishes of individual patients, and to treat them according to criteria which were now defined not by the patient, but by the profession. The relatively powerless position of the hospital patient who was both sick and poor, as well as the patient’s inability to control what happened to his body are, perhaps, most poignantly captured in the words of Entralgo who, in describing the situation in Vienna, has said that the patient had a ‘resigned and submissive attitude’; ‘he handed himself over with a wordless “Here is my body, do what you like with it”’. It is not perhaps surprising that, both in Europe and in the United States, hospital positions became very highly prized within the profession, partly because they gave access to a large amount of ‘clinical material’, as patients came to be called, in the form of a dependent and highly vulnerable hospital population. It was, of course, no accident that the hospital emerged as the centre of both medical research and teaching in the nineteenth century. Equally, it was no accident that it was within the hospital that one first sees the shift from what Jewson has called a ‘person orientated’ to an ‘object orientated’ form of medical practice, for the treatment of large numbers of patients of low status was associated with a process in which the patient was becoming increasingly depersonalised.

It is not suggested, of course, that this radical reversal of the balance of power between doctor and patient occurred in the same sudden and dramatic way in the situation of private practice; nevertheless, a similar process, associated with a decline in the status of the patient, was occurring in private practice throughout the nineteenth century. In the context of a comparative analysis of the degree of authority which physicians have over their patients, Marie Haug has correctly pointed out that the medical practitioner’s ‘degree of authority over clients depends in part on client characteristics rather than occupational characteristics alone’, and it is important to bear in mind that the rise of medical dominance in the nineteenth century was a process which
was associated as much with a lowering of the status of the patient as it was with the raising of the status of the profession.

As we have already noted, within the hospitals medical dominance emerged in its most highly developed form; indeed, it may be said that the hospital was the institutional base for the early development of the modern pattern of medical dominance. This point is of considerable significance, for one aspect of the development of a national market for medical care was that, in relation to the supply of medical men, the process of producing medical practitioners increasingly moved away from the local level, and became centralised in a limited number of hospital medical schools, many of which came to enjoy not merely a local, but also a national — in some cases international — reputation for the quality of both their teaching and research. In order to appreciate the significance of this process of centralisation, it is necessary to bear in mind that, throughout the eighteenth century, the great majority of practitioners — indeed virtually all practitioners — had received their professional education through the apprenticeship system, and this had a number of important consequences. Amongst the more important of these consequences we might note that a highly decentralised, locally-based system of education of this kind made it impossible to control entry to the profession at a national level; perhaps of even greater importance, it also made it quite impossible to enforce any standardised system of education and training. Thus training through the apprenticeship system was likely to be both haphazard and unsystematic; since the apprentice was bound in a personal relationship to his master, the quality of training and education which the apprentice received was largely dependent on the character and the ability of the master to whom he was attached. Thus the country surgeon to whom George Crabbe was apprenticed in 1768 ran a farm in addition to his medical practice with the result that Crabbe found that he ‘was often employed in the drudgery of the farm ... and was made the bedfellow and companion of the ploughboy’.\textsuperscript{68} It is not suggested, of course, that an apprentice could not receive an adequate medical education if he was fortunate enough to be placed
with an able and conscientious master; what is suggested is that the sort of education which the apprentice received almost certainly varied considerably from place to place, and from master to master. Thus not only the clinical training which an apprentice received, but also his socialisation into what may be called the 'jobways' of the profession, including acceptable standards of professional behaviour, were likely to reflect the particular demands of the local community within which his master's practice was situated. The particularistic relationship between doctor and patient in the eighteenth century was thus paralleled, in the sphere of medical education, by an equally particularistic relationship between teacher and pupil.

This traditional system of medical education began to change in the nineteenth century as the apprenticeship system steadily lost ground with the development of an increasingly centralised system of education, at first in the hospital medical schools and subsequently in the universities. Thus, with the growth of the hospital schools, the terms of apprenticeship agreements came to be interpreted very loosely in order to allow apprentices to spend an increasing amount of their time in hospitals; although apprenticeship was never formally abolished, it continued to decline as a means of medical education throughout the second half of the nineteenth century. One consequence of this change in the structure of medical education was that, in place of a particularistic relationship with his master, the medical student in the nineteenth century came increasingly to receive his professional education within a formal institutional context which encouraged shared experiences with other students and, by so doing, facilitated the development of a common professional identity and sense of professional community. As medical students came from all parts of the country to these emerging national and regional centres of medical education, and as large numbers of students passed through the hands of a relatively small number of teachers, the process of medical education became a relatively standardised one in which all students were subjected to broadly similar influences. Moreover, the dominant values within these institutions, well insulated as they were from
the world of lay culture and lay values, were the values of the senior members of the profession. It thus became increasingly possible for this elite group of medical school teachers to define and to some extent to impose on all students their own definition of what constituted minimally acceptable standards of both clinical and ethical behaviour. As a result of these changes in the structure of medical education, medical students underwent a new and more intensive process of professional socialisation which both fostered a sense of professional community and asserted the primacy of professional rather than lay values. The centralisation and standardisation of medical education must therefore be seen as processes of major importance for the development of the modern medical profession, and the control which they came to exercise over the education and professional socialisation of the next generation of medical practitioners was to enable the elite group of medical school teachers to play a major part in shaping this process of professional development.

In this final section, we have examined some of the more important processes associated with the development of medicine as a modern profession. Within the present chapter, it has been argued that the market situation of medical men changed quite radically in the course of the nineteenth century and that, as a consequence, what had formerly been a relatively insecure and often only part-time occupation had, by the end of the century, developed into a relatively stable and secure full-time career. This process of occupational specialisation — the most basic of all processes involved in the development of modern professional occupations — was associated with a significant expansion of the market for medical care, as a result of which medical men were increasingly able to support themselves on the basis of full-time medical practice, without the necessity to engage in other, non-medical activities. In addition, the market situation of medical practitioners was further substantially improved by the effective restriction of entry to the profession, which we examined in a previous chapter. Whereas in the late-eighteenth and early-nineteenth centuries, medical men were involved in a relatively small and very competitive market for their services, by the latter part of
the nineteenth century they were working within a much expanded market, one over which they themselves had a significant degree of control as a result of their ability to restrict the supply of medical practitioners. It is, of course, not surprising that these changes within the structure of the market for medical care resulted, as we saw previously, in a significant improvement in medical incomes in the latter part of the nineteenth century.

Changes in the structure of the medical profession were not, however, limited to changes in the market situation of medical practitioners considered in purely economic terms, though the importance of these changes should not, of course, be underestimated. However, it has been argued that both the growth in the size of the market for medical care, and changes in the structure of that market, were also associated with a weakening of a variety of locally-based forms of client control, such as that involved in the patronage system. Within this context medical men were, albeit very gradually, able to develop a network of new institutions which increasingly had the effect of centralising the control of more and more aspects of medical practice within the profession itself. In previous chapters, we have examined some major aspects of this movement towards professional self-regulation, including the early development and subsequently the more effective enforcement of codes of medical ethics and, closely associated with this, the development of the General Medical Council as the central controlling body within the profession. These developments, as we have seen, took place within a context of struggle and conflict within the profession, but out of these struggles there gradually developed, in the second half of the century, new institutions which provided the basis for a more united profession, characterised by a growing sense of professional community and professional identity. This growing professional consciousness was further enhanced by changes in the structure of medical education, as the process of producing the next generation of practitioners increasingly moved away from the local level and became centralised in a limited number of specialist institutions. As a result of this development, the process of professional socialisation became
one in which all students were exposed to broadly similar
influences under the tutelage of senior medical school
teachers who were themselves increasingly able to assert the
primacy of professional values over those of the lay world.
As a consequence of this whole complex of interrelated
processes, medical men in the second half of the nineteenth
century came to enjoy a relatively secure and steadily
improving market situation and, equally importantly, a
steadily increasing degree of control over their work, their
patients, and their own careers. Medicine, in other words,
was beginning to emerge as a modern profession.
Chapter One


Notes


10. *Select Committee on Medical Education*, 1834 (602-1) Part I, Q 511. Hereafter, this Select Committee will be referred to as SCME.
11. SCME, 1834, Part I, Q 3014.
12. As Singer and Holloway have noted, 'the medical departments at Oxford and Cambridge were merely nominal until after the middle of the nineteenth century'. See Singer and Holloway, 'Early Medical Education in England', *Medical History*, IV/1, 2.
Chapter Two

3. SCME, 1834, Part I, Q 2257.
6. First and Second Reports from the Select Committee on Medical Registration and Medical Law Amendment, 1847-48, (210), Q 1215.
9. SCME, 1834, Part II, Q 5980.
11. SCME, 1834, Part I, Q 2470.
13. SCME, 1834, Part II, Q 5679-83.
17. First and Second Reports, 1847-48, Q 268-9.
20. First and Second Reports, 1847-48, Q 1227.
22. Ibid, Q 4791, 5372.  23. Ibid, Q 6299.
24. First and Second Reports, 1847-48, Q 495.
27. Lancet, 1841-42, i, 422.
28. In 1856, the Association Medical Journal estimated that 'there are 2,603 gentlemen practising medicine and surgery with only one qualification', of whom 879 held only the licence of the Apothe-
In his detailed study of medical practitioners in mid-nineteenth century Bristol, Brown found that two-thirds of those holding only the licence of the Apothecaries' Society described themselves as general practitioners. See P S Brown, 'The Providers of Medical Treatment in Mid-Nineteenth Century Bristol', Medical History, XXIV, 1980, 302.

29. SCME, 1834, Part II, Appendix 44, 87.
30. First and Second Reports, 1847-48, Q 1061-4.
31. Ibid, Q 934. 32. Ibid, Appendix, 133.
33. Holloway, 'Medical Education in England', 314.
34. London and Provincial Medical Directory, 1847, xv-xvi.
36. See, for example, Waddington, 'The Struggle to Reform', 107-26.
37. London and Provincial Medical Directory, 1847, xvi.
40. London and Provincial Medical Directory, 1847, xvi.
44. Peterson, The Medical Profession, 12.
47. Carr-Saunders and Wilson, The Professions, 71.
49. Carr-Saunders and Wilson, The Professions, 71.
50. As numerous social historians have pointed out, in the eighteenth century high status was associated with the ownership of landed property rather than with the performance of occupational tasks. In addition, a particularly important cleavage within the social hierarchy was that which separated gentlemen from the 'common people', a division which, as Perkin has noted, 'could scarcely be defined in economic terms'. Rather, the distinction appears to have been made in terms of a combination of birth, manners, speech, deportment and social acceptance. By comparison with these attributes, work — no matter how skilled — was a very poor claim to high status; indeed, ideally a gentleman was expected to maintain a leisureed lifestyle without actively working to support it.

60. Holloway, 'Medical Education in England', 316.
62. SCME, 1834, Part I, Q 3534-5.
65. Many working class people, like the unfortunate Bessy Higgins in Mrs Gaskell's *North and South*, probably suffered serious illness and death without being attended by a qualified practitioner. As William Lawrence pointed out in 1847, poor people 'cannot afford to employ a well qualified practitioner. For one-sixth of the expense, or even much less, they get what seems to them to answer the purpose equally well from the chemist and druggist.' See *Report from the Select Committee on Medical Registration*, 1847 (620), Q 1962.
67. Peterson, *The Medical Profession*, especially Chapter IV.

Chapter Three
27. Lancet, 1823-24, ii, 199.
28. Walter Rivington, The Medical Profession, Dublin, 1879, 3-4. Differences in the provision of medical care ranged from one medical man to 210 persons in Buxton, to one to 6,295 in Aberdare.
30. Ibid, 6.
32. H N Hardy, The State of the Medical Profession in Great Britain and Ireland in 1900, Dublin, 1901, 70.
33. Lancet, 1875, ii, 512.
34. Lancet, 1875, ii, 580.
Chapter Four

16. The conflict within the College was reported in *The Times*, June 22, 1827, and June 28, 1827, whilst on June 25, the *Morning Chronicle* published a letter from William Lawrence, who had taken an active part in the members' campaign.  
20. A detailed report of the meeting may be found in *Lancet*, 1830-31, i, 694-700.  
23. A full report of these events at the College may be found in *Lancet*, 1830-31, i, 785-797. The announcement that the order relating to naval surgeons had been withdrawn was made in *Lancet*, 1830-31, i, 822.  
26. A short report of this meeting may be found in *Lancet*, 1830-31, i, 821-23, and a longer report in the same volume, 846-865.  
33. Sprigge, *The Life and Times*, 221.  
38. SCME, 1834, Part II, Appendix 7, and Part III, Appendix 7. In the five year period from 1829-33 inclusive, the College of Surgeons examined 2324 candidates; in the similar period from 1829-30 to 1833-4, the Society of Apothecaries examined 2246.  
40. See, for example, the petitions presented to Parliament by the licentiates of the Royal College of Physicians, *Lancet*, 1840-41, ii, 668-70.  
42. *Ibid*, 1836-37, i, 227, 597.  
44. *Ibid*, 1836-37, i, 594-5.  
45. *Ibid*, 1836-37, i, 596.  
46. *Ibid*, 1836-37, i, 596.  
47. *Ibid*, 1836-37, i, 576.  
52. *Ibid*, 1836-37, i, 644-5.  
53. *Ibid*, 1836-37, i, 77, and 1840-41, i, 117.  
57. *Ibid*, 1839-40, i, 94.  
Chapter Five
1. Much of the early work of both the SMA and the PMSA in relation to the system of poor law medical relief is documented in W.F. McMenemey, The Life and Times of Charles Hastings.
4. Graham's Bill may be found in British Sessional Papers, House of Commons, 1844 (600), III, 235-246.
5. As Charles Newman has correctly noted, under Graham's Bill, 'the "orders" were . . . not only maintained, but provided with progressively increasing requirements to correspond with their progressive status'. See Newman, The Evolution of Medical Education, 169-60. In this progressive hierarchy the general practitioners were, of course, to be at the bottom.
7. First and Second Reports, 1847-48, Q 934.
8. Ibid, Q 935. 9. Ibid, Q 935. 10. Ibid, Q 1149-50, 1152.
13. First and Second Reports, 1847-48, Q 942-944.
17. British Sessional Papers, House of Commons, 1845 (283), 499-516.
20. Lancet, 1845, 8, 561, 564.
21. The memorial from the College of Physicians was reprinted in the Report from the Select Committee on Medical Registration, 1847, Q 681.
22. First and Second Reports, 1847-48, Q 1167. See also Cope, The Royal College of Surgeons, 77-8.
23. British Sessional Papers, House of Commons, 1845 (579), IV, 517-530.
24. First and Second Reports, 1847-48, Q 745.
25. The statement of 'Principles' was reproduced as Appendix II to the Third Report from the Select Committee, 1848, pp 381-9.
26. First and Second Reports, 1847-48, Q 1008.
27. Ibid, Q 1164. 28. Ibid, Q 1166.
29. Ibid, Q 1167-8. 30. Ibid, Q 1420.
31. Ibid, Q 1433, 1435. 32. Ibid, Q 1375.
33. Minutes of Council, Royal College of Surgeons, 16 March 1849.
34. The last meeting between the medical corporations and the National Institute appears to have been on 9 February 1850. See Cope, The Royal College of Surgeons, 94-5.
35. Lancet, 1825-6, 733.
38. First and Second Reports, 1847-48, Q 1152.
39. Report from the Select Committee on Medical Registration, 1847, Q 57.
40. Ibid, Q 1186. 41. Ibid, Q 1576. 42. Ibid, Q 2031.
43. Wakley's Bill was printed in full in Lancet, 1847, 466-70.
45. Minutes of Council, Royal College of Surgeons, 3 May 1847.
46. Ibid, 10 June 1847.
47. Report from the Select Committee on Medical Registration, 1847, Q 62-3.
48. Ibid, Q 89. 49. Ibid, Q 1146.
50. Ibid, Q 1106. 51. Ibid, Q 1187.
52. Ibid, Q 1462-3. 53. Ibid, Q 104.
54. Ibid, Q 1650. 55. Ibid, Q 1695.
56. Ibid, Q 1577. 57. Ibid, Q 2010-2011.
58. First and Second Reports, 1847-48, Q 138.
59. Ibid, Q 305.

Chapter Six
2. The memorandum was entitled 'To the Right Hon W F Cowper, MP and the other Members of the Select Committee to which the Medical Bills have been referred' and dated 23 April 1856. In the library of the Royal College of Physicians in London there are two box files labelled 'Medical Reform' which contain a collection of apparently uncatalogued documents relating to the medical reform movement in the 1840s and 1850s; a copy of the College's memorandum to the Select Committee is contained in one of these boxes. In subsequent references, these boxes. In subsequent references, these boxes will be referred to as 'Medical reform boxes', RCP.
4. Minutes of Council, Royal College of Surgeons, 7 August 1856.
5. Ibid, 16 October 1856.
6. The minutes of this conference are contained in 'Medical reform boxes', RCP.
7. Minutes of Council, RCS, 30 October 1856.
9. According to the minutes of the conference, it was agreed that seven clauses of Headlam's Bill of February 1856 should be incorporated in the Corporations' Bill.
10. This information is contained in a letter dated 27 January 1857 from John Simon to Francis Hawkins, the Registrar of the College. The original of this letter may be found in 'Medical reform boxes', RCP.
11. It was in December 1857 that Cowper announced his intention of bringing in a Bill; whether he was thinking along these lines in January 1857 one cannot, of course, say.


15. Report from the Select Committee on Medical Registration, 1847, Q 104.

16. 'To the Right Hon. W. F. Cowper, M.P. and other Members of the Select Committee', 23 April 1856, 'Medical reform boxes', RCP.

17. This was stipulated in Clause XXI of the Corporations' Bill.


20. Ibid, Clause XXII. 21. Ibid, Clause XXIII.


24. A copy of the College's petition to the Commons may be found in 'Medical reform boxes', RCP.

25. 'Medical reform boxes', RCP.

26. Minutes of Council, RCS, 10 June 1857.

27. Hansard, CXLVI, 1 July 1857, col 709-10.


32. The minutes of this meeting are recorded in a printed document simply headed Royal College of Physicians, in 'Medical reform boxes', RCP.

33. Minutes of Council, RCS, 15 March 1858.

34. Document headed Royal College of Physicians, in 'Medical reform boxes', RCP.

35. 'Memorandum prepared in 1858 by the Medical Officer of the then General Board of Health (Mr Simon), in explanation of the Medical Practitioners Bill of that year, as drawn for the Board under Mr Cowper's presidency', in Special Report from the Select Committee on the Medical Act (1858) Amendment (No 3) Bill (Lords), British Sessional Papers, 1878-79, xii, Appendix 1, 305-310.


39. Cowper's Bill, as introduced into the Commons, may be found in British Sessional Papers, 1857-58, (37), III, 461-476.

40. 'Memorandum prepared in 1858', 307.

41. Ibid, 309. 42. Ibid, 308.

43. The Bill stipulated that those who sat on the General Medical Council as representatives of the medical corporations and universities must be qualified to register under the Act. This condition did not, however, apply to the six additional members of Council, thus implying the possibility that some lay persons could sit on the Council.

44. Lancet, 1858, i, 368. 45. Ibid, 390. 46. Ibid, 416.


53. Ibid, 617.

54. At its meeting on 8 April 1858, the Council of the College of
Surgeons decided that Cowper's Bill 'is not entitled to the support of this Council' and the other London corporations took a similar view at a conference held on 13 April, and reported in the Minutes of Council, RCS, 14 April 1858.

55. Minutes of Council, RCS, 22 April 1858.
56. Ibid, 13 May 1858.
57. Hansard, Third series, CL, 2 June 1858, col 1412.
58. Lancet, 1858, i, 416.
62. The College of Physicians presented a single petition against all three Bills, that is, the Bills of Cowper, Elcho and Duncombe. The text of this petition may be found in the Royal College of Physicians' Annals, vol 25, 1852-58, 14 April 1858.
63. Hansard, Third series, CL, 2 June 1858, col 1408.
64. Minutes of Council, RCS, 10 June 1858.
70. The amended version of Cowper's Bill may be found in British Sessional Papers, House of Commons, 1857-58 (152), III, 477-92.
71. Special Report from the Select Committee on the Medical Act (1858) Amendment (No. 3) Bill (Lords), British Sessional Papers, 1878-9, Q 558-9.
72. As we shall see, Simon was to denounce the corporations for their 'utter corruption' in a speech which he made in 1868.
73. Hansard, Third series, CLI, 6 July 1858, col 996.
75. Lancet, 1858, ii, 147.
76. Ibid, 175.
77. Minutes of Council, RCS, 14 October 1858.
78. Lancet, 1858, ii, 459.
79. Minutes of Council, RCS, 11 November 1858.
80. Ibid, 11 November 1858.
81. Newman, The Evolution of Medical Education, chapter V.
82. Lancet, 1858, ii, 175.
83. Ibid, 205.
84. Ibid, 458.
85. Ibid, 147.
86. Ibid, 205.
87. Ibid, 458.
88. Special Report from the Select Committee on the Medical Act (1858), British Sessional Papers, 1878-9, Q 553, 561.
89. Memorandum prepared in 1873 by the then Medical Officer of the Privy Council (Mr Simon) on the Constitution of the General Medical Council, as fixed by the Medical Act, 1858, and on certain Proposals for changing that Constitution, Special Report from the Select Committee on the Medical Act, 1878-9, Appendix 2, 330.
91. Ibid, 468.
92. Minutes of Council, RCS, 12 August 1858.
94. Ibid, 1858, i, 440.
Chapter Seven

9. Ibid, 89.
10. 'Medical Reform', Quarterly Review, 1840-41, LXVII, 64.
13. SCME, 1834, Part II, (602-II), Appendix 2.
18. Lancet, 1847, i, 135.
19. Musgrove, 'Middle-class Education', 106.
28. See, for example, Hansard, LXXVI 1844, col 1910, and Lancet, 1841-42, ii, 133, and Lancet, 1858, ii, 120.
34. Ibid, 57. 35. Ibid, 60. 36. Ibid, 56.
38. Ibid, 1847, i, 627.
39. David L Cowan, 'Liberty, Laissez-faire and Licensure in Nineteenth

40. These restrictions were set out in Clause 36 of the Act.


42. Berlant, Profession and Monopoly, 156.

43. Hansard, LXXVI, 1844, col 1898.

44. Berlant, Profession and Monopoly, 167.

45. These census figures are taken from Musgrove, op. cit., 105. It should be noted, however, that Musgrove's figure of 15,901 practitioners in 1881 is a mistake; this should read 15,091.

46. The percentage growth of the employed male population and of the total population has been calculated from the figures in H J Perkin, 'Middle-class Education and Employment in the Nineteenth Century: A Critical Note', Economic History Review, second series, 14, 1961-62, 128.

47. When Rivington calculated doctor-patient ratios in his Carmichael Prize essay of 1879, he used slightly different figures for the increase in the total population from those given in Perkin's article. However, those differences were too small to make any significant difference between his conclusions and those set out in this chapter. Thus Rivington calculated that the reduction in the provision of qualified medical care had been from 7.2 doctors per 10,000 population in England and Wales in 1861, to 6.4 per 10,000 in 1871. See Walter Rivington, The Medical Profession, Dublin, 1879, 2.

48. In 1861 there was one practitioner for every 1392 persons, and in 1911 one to every 1469.


51. Ibid, Q 1165. 52. Ibid, Q 1166. 53. Ibid, Q 1168.

54. Report of the Committee appointed by the Secretary of State to enquire into the causes which tend to prevent sufficient eligible candidates from coming forward for the Army Medical Department, 1878 (C-2200), 28-9.


Chapter Eight


2. Chauncy D Leake (ed), Percival's Medical Ethics, Baltimore, 1927, 36.


5. R M S McConaghey, 'Medical Ethics in a Changing World', Journal
of the College of General Practitioners, 1965: 10: 3-17.
9. The rules and bye-laws of the Manchester Medico-Ethical Association were published in 1848, and reviewed in an anonymous article entitled 'Medical ethics', British and Foreign Medico-Chirurgical Review, 1848, 2: 1-30.
10. Ernest Muirhead Little, History of the British Medical Association 1832-1932, London, n.d, 288. In 1853 the Association was, of course, still called the Provincial Medical and Surgical Association.
14. Leake, Percival's Medical Ethics, 71.
15. Ibid, 90.
17. Ibid, 73.
18. Ibid, 90.
19. Ibid, 80.
20. Ibid, 81.
22. Ibid, 2.
23. Ibid, 1.
24. Ibid, 30-32.
25. Ibid, 37.
27. Banks, Medical Etiquette.
28. See, for example, Lancet, 1839-40, ii, 875; 1839-40, ii, 942; 1840-41, i, 68-9; 1841-2, i, 549; 1847, ii, 266-7; 1848, ii, 538; 1850, ii, 186-7; 1850, ii, 249; 1850, ii, 489-90; 1850, ii, 621.
29. Banks, Medical Etiquette, 1-4.
30. Lancet, 1845, ii, 492.
33. Banks, Medical Etiquette, 39.
37. Banks, Medical Etiquette, 57.
38. Porter, Medical Science and Ethicks, 29.
40. Lancet, 1845, ii, 687.
Chapter Nine

2. E Freidson, Profession of Medicine, New York, 1972, 71.
6. Ibid, 47.
9. Freidson, Profession of Medicine, 12.
10. In relation to legal services, for example, it has been pointed out that in the eighteenth century 'the vast bulk of the population had no demand for legal services'. See B Abel-Smith and R Stevens, *Lawyers and the Courts*, London, 1970, 14.


15. Starr, 'Medicine, Economy and Society', 51.


19. As late as 1840, there were still only seventy-six physicians who were licensed by the College to practise outside of London. In the middle 1840s this number began to increase more rapidly, and had reached 293 by 1847. See Clark, *A History of The Royal College of Physicians*, vol II, Appendix II, 739.


24. Starr, 'Medicine, Economy and Society', 51.

25. Amongst the more famous of those who left the medical profession after failing to secure an adequate income from medical practice were George Crabbe, Tobias Smollett and Oliver Goldsmith. The biographies of unsuccessful practitioners are as important as — indeed, perhaps more important than — those of successful practitioners in terms of what they tell us about the structure of medical careers. Unfortunately, the biographies of unsuccessful practitioners are, of course, rarely written, and we know of the cases cited above only because, having failed in medical practice, they subsequently achieved fame in the world of literature. How many unsuccessful practitioners there were who never achieved fame in another field, and whose biographies were therefore never written, we cannot know, but the number was probably considerable.


38. On the development of pharmacists as a specialised occupational group, see Carr-Saunders and Wilson, *The Professions*, 132-41.


44. Dirk Jan Baptist Ringeir, *Plattelandschirurgijns in De 17e en 18e Eeuw*, Bunnik, Uitgeverij Lebo, 1977, especially 86-92. I am grateful to Henk Heijnen of the Sociologisch Instituut, Universiteit van Amsterdam, for bringing this reference to my notice.


47. *Ibid*, 376.


49. Holloway, 'Medical Education in England', 317.

50. The increasing intellectual detachment of the nineteenth-century medical scientist, and the concomitant growth of his social detachment from the patient is analysed in N D Jewson, 'The Disappearance of the Sick-man from Medical Cosmology, 1770-1870', *Sociology*, 1976, 10, 225-244.


54. Freidson uses these terms primarily to highlight differences in the
work situation of those involved in 'neighbourhood practice' as opposed to hospital practice in modern American society. However, it may be argued that the work situation of many practitioners in eighteenth-century England provides a much more clear cut and extreme form of 'client-dependent' practice.

55. For a description of one of the earliest local medical societies in England, see Arthur Rook, 'General practice, 1793-1805: the Transactions of a Huntingdonshire Medical Society', Medical History, 1960, 4, 236-52. Other early medical societies were those at Warrington (1770), Colchester (1774), Plymouth (1794), and Leicester (1800).


57. Quoted in Holloway, 'Medical Education in England', 318.

58. Ibid, 316.


60. Starr, 'Medicine, Economy and Society', 51.

61. Holloway, 'Medical Education in England', 320.


63. Some of the implications of this change in the balance of power between doctor and patient have been analysed in relation to the situation in France in I Waddington, 'The Role of the Hospital in the Development of Modern Medicine: a Sociological Analysis', Sociology, 1973, 7, 211-224. Information on the situation in American hospitals may be found in Morris J Vogel, 'Patrons, Practitioners and Patients: the Voluntary Hospital in Mid-Victorian Boston', in D W Howe (ed), Victorian America, Philadelphia, 1976, 121-138. A good deal of information relating to the treatment of hospital patients in Britain during this period may be found in F B Smith, The People's Health, 1830-1910, London, 1979, whilst some information on the situation in Viennese hospitals may be found in P Lain Entralgo, Doctor and Patient, New York and Toronto, 1969.

64. Entralgo, Doctor and Patient, 117.

65. The reference to patients as 'clinical material' is taken from Charles Bell Keatley's The Student's and Junior Practitioner's Guide to the Medical Profession, London, 1885, cited in Peterson, The Medical Profession, 174. Keatley praised the resources of a teaching hospital in the following terms: 'The clinical material is simply overflowing, especially in the surgical and gynaecological departments, and there is any amount of opportunity for men to work clinically at dresser-ships and clerkships, if they will only come and finger the material...
for themselves. It is a perfect paradise for every kind of tumour known, and the accidents are numerous.' The whole tone of Keatley's comments provides a clear illustration of the extent to which medicine had become, in Jewson's words, 'object orientated' rather than 'person orientated'.

68. The Life of George Crabbe, 17.
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At a Conference at the Royal College of Surgeons of England, 21 October — 24 October, 1856 (minutes of conference)
Medical Reform Reasons, on Behalf of the Medical Incorporations, in Favour of Mr Headlam's Medical Bill, and Against that of Lord Elcho, 1857
Remarks on Mr Headlam's "Medical Profession Bill", and Lord Elcho's Opposition (nd)
A Short Statement of the Respective Merits of the Medical Bills now before Parliament (nd)
Brief Display of the Essential Points in Mr Headlam's Bill and in the Counter Bill of Lord Elcho (nd)
The last three documents are not dated, but since they all relate to the Bills introduced by Mr Headlam and Lord Elcho in 1857 it may safely be presumed that they were printed in that year.

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SECTION THREE
The Relationship between Social Class and the use of Health Services in Britain

*Journal of Advanced Nursing, 2, 1977, pp 609-619*
The relationship between social class and the use of health services in Britain

WADDINGTON IVAN (1977) Journal of Advanced Nursing 2, 609-619

The relationship between social class and the use of health services in Britain
There is considerable evidence to suggest that despite the availability of free medical services under the British National Health Service, there remains a clear social class bias in accessibility to a wide range of health care services. The literature on social class and the use of health services is examined and it is suggested that the greatest inequalities are to be found in the use of preventive services. In the second half of the paper, some tentative proposals, which might serve to reduce existing patterns of inequality, are examined.

INTRODUCTION
In the past 20 years a considerable body of evidence has been accumulated by both social scientists and doctors (especially those involved in social medicine), which indicates that, despite the availability of universal free-on-demand medical services under the British National Health Service (NHS), the use of certain kinds of medical services continues to show a high positive correlation with social class (i.e. the higher the social class, the more intensive use is made of health services). The implication is, then, that there are various non-economic barriers to the equalization of health care and that these barriers serve to maintain an important element of inequality within the NHS. At the present time, when a Royal Commission is investigating all aspects of the NHS, it may be appropriate to outline the nature and extent of that inequality and to suggest, albeit tentatively, some ways in which that inequality might be reduced.

The relationship between social class and use of health services is a complex one and the nature of the relationship appears to vary depending upon which specific type of health service one examines. In the following sections the existing state of knowledge relating to use of general practitioner and in-hospital services, and preventive medical services, is outlined and discussed.
USE OF GENERAL PRACTITIONER AND IN-HOSPITAL SERVICES

A few years ago, Rein (1969) reviewed a number of studies which, he claimed, indicated that manual workers and their families make greater use of in-hospital and general practitioner (GP) services than do non-manual workers and their families. Rein has, however, recently been criticized for being 'selective in the examples he used, choosing those which supported his thesis and ignoring other findings' (Cartwright & O'Brien 1976), and it would be wrong to accept at face-value Rein's conclusion that the 'British Health Service is equitable'. Even if one accepted Rein's conclusion that manual workers make more intensive use of in-hospital and GP services, the most likely explanation of this would be that this pattern of usage simply reflects higher levels of morbidity among manual workers and, without relating use to need (morbidity), it is difficult to make any firm statement about under- or over-utilization of services. In fact, however, there is some evidence which runs counter to that cited by Rein. Thus, in an analysis of Scottish general practice, Picken & Ireland (1969) found that there was no significant relationship between social class and the level of consultation for adults, but that 'children from upper social class families and from smaller families tend to consult relatively more often than other children'. More recently, Cartwright & O'Brien (1976) have suggested that a simple comparison of the annual consultation rates of different social classes may be a very crude instrument for trying to assess which groups benefit more from GP services. They found that the average length of 'conversation time' was greater at consultations with middle-class patients (6-2 minutes) than with working-class patients (4-7 minutes). This is consistent with the earlier work of Buchan & Richardson (1973) who found a clear social class gradient, in the 'face-to-face' duration of consultation, from 6-1 minutes for those in social class 1 to 4-4 minutes for those in social class 5. Cartwright & O'Brien also found that GP's had more knowledge of the personal and domestic situations of their middle-class patients compared with their working-class patients despite the fact that working-class patients tended to have been with the practice for a longer period of time (an average of 13-9 years compared with 10-1 years). They also suggested that middle-class patients were able to make better use of the consultation time, as measured by the number of items of information communicated to the doctor and the number of questions which they asked. Finally, and again this relates to the quality of the consultation, it is worth noting that there is a consistent relationship between the tendency of the better qualified and more able doctors to practise in desirable, predominantly middle-class areas of Southern England, and of the less well-qualified doctors to practise in what are generally held to be the less desirable, predominantly working-class industrial and mining areas of the North. As Julian Tudor Hart (1971) has commented, 'the doctors most able to choose where they will work go to middle-class areas and . . . the areas with highest mortality and morbidity tend to get those doctors who are least able to choose where they will work'.
Rein's (1969) conclusion in relation to use of hospital services is also open to doubt and, as in the case of use of GP services, there is evidence (Howlatt & Ashley 1972, Alexander & Dunnett 1974) which runs counter to that presented by Rein. There is, however, no need to go into further detail, for enough has been said to indicate that there is conflicting data on the relationship between social class and the use of GP and in-hospital services, and that the nature of this relationship is still open to differing interpretations. Whatever the precise nature of this relationship may be, however, it is probably fair to say that the development of the NHS has eliminated at least the more gross social class differentials, for none of the studies cited above indicates that there is a major problem of under-utilization of these services by any specific group.

USE OF PREVENTIVE SERVICES

If we turn, however, to an examination of the use of preventive services, we find a sizeable body of data which consistently points to the continued existence of very large social class differentials in the use of these services. The existence of these differentials in the use of preventive services is well-established and the following section attempts to summarize some of the more important findings in relation to this problem.

For some time it has been known that the incidence of cervical cancer is related to a number of social variables, one of which is social class. This relationship is an inverse one (i.e. the lower the social class, the higher the incidence of cervical cancer) and recent figures from The Registrar-General (1971) show that the standardized mortality ratio for cancer of the cervix is almost six times greater in social class 5 than in social class 1. Furthermore, women from social classes 4 and 5 (i.e. wives of semi-skilled and unskilled manual workers) are massively under-represented amongst women who use the existing facilities for cervical smear screening, whilst those from the higher social classes are over-represented. For example, a recent study in the Manchester area (Sansom, Wakefield & Yule 1972) indicated that while women from social classes 4 and 5 accounted for over one-third of all women living in the Manchester area, they constituted only 15-16% of those women who had had a smear test done (see Table 1).

From Table 1 it is clear that social classes 1-3 are over-represented in the screened population, while social classes 4 and 5 are under-represented. Wakefield (1972) and his colleagues demonstrated that there was a serious problem of under-utilization by women in the lower social classes (i.e. those most at risk were least likely to use the service).

Dental services

A similar picture emerges with a variety of other services. The study by Bulman et al. (1968) indicated that the lower a person's social class the less likely he was to use dental services, especially for conservative dentistry. Their data from the Salisbury area of Wiltshire indicated that whereas 49% of people in social classes 1
and 2 reported having visited a dentist within the previous 12 months, only 9% of people in social class 5 had done so. At the other extreme, no less than 32% of people in social class 5 had not visited a dentist within the previous 15 years, as compared with 8% in social classes 1 and 2, whilst 5% of those in social class 5 had never been to a dentist (see Table 2). All those who participated in this study were given a full dental examination and it was found that people in social class 5 had, on average, fewer teeth than members of other social classes, had a higher proportion of decayed teeth, more periodontal disease, and more of them wore either full or partial dentures. Thus, once again this study indicated that the problem of under-utilization was most serious amongst those who had the greatest need for dental services.

Alderson (1970) has reviewed data on the relationship between social class and the use of a number of health care services. The services he examined, besides cervical cytology and dentistry, were mass miniature radiography, use of infant welfare clinics, arrangements for delivery, and use of family doctor in first year of life. Two services (mass miniature radiography and infant welfare clinics) were used most intensively by social class 3, but for all services there was evidence of

<table>
<thead>
<tr>
<th>Social class</th>
<th>1966 census (N.W. region less Merseyside)</th>
<th>1965 profile of screened women (n = 5,000)</th>
<th>1968 analysis of screened women (n = 34,851)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>1</td>
<td>2.6</td>
<td>6.5</td>
<td>7.7</td>
</tr>
<tr>
<td>2</td>
<td>15.5</td>
<td>19.3</td>
<td>20.1</td>
</tr>
<tr>
<td>3</td>
<td>48.2</td>
<td>57.3</td>
<td>57.0</td>
</tr>
<tr>
<td>4</td>
<td>25.6</td>
<td>10.6</td>
<td>11.1</td>
</tr>
<tr>
<td>5</td>
<td>8.3</td>
<td>6.3</td>
<td>4.1</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last visit to dentist</th>
<th>Social class</th>
<th>1-2</th>
<th>3 (non-manual)</th>
<th>3 (manual)</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 6 months</td>
<td></td>
<td>35</td>
<td>30</td>
<td>19</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td></td>
<td>14</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>1-2 years</td>
<td></td>
<td>13</td>
<td>13</td>
<td>10</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>2-5 years</td>
<td></td>
<td>19</td>
<td>17</td>
<td>22</td>
<td>21</td>
<td>14</td>
</tr>
<tr>
<td>5-10 years</td>
<td></td>
<td>5</td>
<td>9</td>
<td>18</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>10-15 years</td>
<td></td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Over 15 years</td>
<td></td>
<td>8</td>
<td>18</td>
<td>16</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>Don't know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never been</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
<td>100</td>
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<td>100</td>
<td>100</td>
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</table>
under use by social classes 4 and 5, which became more serious when juxtaposed 
with data on morbidity. As an example, the data on mass miniature radiography 
are reproduced in Table 3.

**Table 3**  
Proportion of persons by social class having one or more MMR 
examinations and age-standardized abnormality rate amongst males having 
their first x-ray 

<table>
<thead>
<tr>
<th>Social class</th>
<th>Examinations/1000 persons</th>
<th>Abnormality rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>294</td>
<td>74</td>
</tr>
<tr>
<td>2</td>
<td>246</td>
<td>74</td>
</tr>
<tr>
<td>3</td>
<td>348</td>
<td>99</td>
</tr>
<tr>
<td>4</td>
<td>244</td>
<td>94</td>
</tr>
<tr>
<td>5</td>
<td>243</td>
<td>125</td>
</tr>
</tbody>
</table>

The data on infant welfare clinics used by Alderson (Spence et al. 1954, 
Douglas & Blomfield 1958) is now rather old, although it should be noted, as 
Alderson points out, that these studies were reviewed in a report by the Sub-
Committee of the Standing Medical Advisory Committee (1967), which stated 
that there was no reason to think that the position had materially altered and that 
no comparable work had since been done. The general conclusion at which 
Alderson (1970) arrived was that the 'data presented are compatible with the 
hypothesis that there is a group in the community who are aware of the provisions 
of the health service and who obtain a higher proportion of the resources of the 
health service than would be expected by chance, and a much higher proportion 
in relation to their needs when compared with others in the community'.

**Family planning services**
Additional evidence that the middle-class make greater use of preventive services 
comes from studies of family planning services. Cartwright (1970) found clear 
social class gradients in the proportion of women attending a family planning 
clinic and discussing birth control with their general practitioners. Not surprisingly, 
she also found that working-class women had more unintended pregnancies. Bone 
(1973) similarly found that the middle (non-manual) classes made more use of 
family planning services than the working (manual) classes. Cartwright’s (1970) 
study also found clear class gradients in the proportion of mothers having an 
antenatal examination, thus indicating that the inequalities earlier identified by 
Martin (1954) still persisted. Again, non-utilization or late attendance at antenatal 
clinics is more widespread in those groups known to be most at risk (i.e. the 
unmarried, the lower social classes and the higher parities).

There is, therefore, strong evidence to suggest that there remains a clear social 
class bias in accessibility to a wide range of services and that NHS resources are 
not being accurately matched to needs. Indeed, the general conclusion which can 
be drawn from the evidence cited above is probably best summed up in Julian 
Tudor Hart’s (1971) formulation of what he called ‘the inverse care law’ i.e. ‘that 
the availability of good medical care tends to vary inversely with the need of the 
population served’.
WHAT CAN BE DONE TO REDUCE INEQUALITY OF HEALTH CARE?

Having examined, albeit in a very brief way, some of the data relating to the use of British health services, it may now be appropriate to examine some possible ways of reducing existing inequalities and thus helping to more accurately match resources to medical needs.

Perhaps the first point to be made is that insofar as the NHS has been successful in reducing the inequality of health care—and it does appear to have had some success, at least in relation to hospital and general practitioner services—it has done so because it has, to a very considerable extent, divorced health care from the ability to pay. Both the experience of Britain prior to the development of the NHS, and that of the contemporary USA (Anderson & Andersen 1972, Alpert et al. 1969), indicate that where the provision of health care is left either wholly or partly to the operation of market forces, the resulting inequalities are far greater than where the provision of health care is removed from the market. It is within this context that proposals for introducing charges for general practitioner consultations, or 'hotel' charges for hospital care, ideas which are currently being discussed in some quarters in the United Kingdom, should be seen. Any breach of the fundamental principle that health care should be free at the time of need will have the inevitable consequence of recreating those forms of inequality (in access to general practitioner and hospital care) which it has been the major achievement of the NHS to reduce or eliminate. It is worth emphasizing that this consequence will follow even if the proposed level of charges is comparatively 'modest' and even if there is a 'generous' system of exemptions. What appears a 'modest' charge to professional people may well be anything but modest to those immediately above the cut-off point for free services, whilst we know from the operation of a wide variety of means-tested benefits that there are a large number of people who, for a variety of reasons, do not claim those benefits to which they are entitled. Whatever the faults of the NHS, and its friends as well as its enemies would recognize that there are many, it is a health system which is based on the most civilized principles. Any attempt to revert to a situation in which health care reflects ability to pay rather than medical need, can serve only to exaggerate existing inequalities in health care and it would, for that reason, be a less civilized health service.

A second point of major importance is that the unequal distribution of resources between regions serves to mask the unequal distribution of resources between different groups within the community. Noyce, Snaith & Trickey (1974) have recently analysed regional variations in expenditure in the three branches of the health service. They found a significant positive correlation between the percentage of the population in professional and managerial occupations and both community health expenditure and hospital revenue expenditure. There was a negative correlation between the percentage of the population in unskilled and semi-skilled manual occupations and both community health and hospital revenue expenditure.
expenditure: 'where these (social class 5) people are most abundant, fewest resources are available'. They further noted that 'as late as 1971-1972 no effort was achieving success in directing new capital to deprived regions'. It is clear that a strong case exists for the development of a more vigorous policy to redistribute resources between regions and areas and that this would also have the consequence of redistributing resources towards the lower income groups, who form a higher proportion of the population in these deprived areas.

Finally, it may be useful to examine one or two ideas which have been suggested as a way of reducing the existing inequalities in the use of preventive services. It should be emphasized that this is not meant to be an exhaustive list of suggestions, but simply a starting point for the examination of this problem.

HEALTH CARE ORGANIZATION

As a preliminary observation, it is of course true that one cannot compel people to use health services and it would be wrong to force those who do not wish to use health services to do so. Nevertheless, it is legitimate to examine ways in which the organization of health services might be changed so as to reduce what is often a hiatus between the very formal, bureaucratic way in which those services are organized and the life-style and expectations of working-class people. Importantly, a number of proposals in this area would involve relatively little expense. One such idea was thrown up by the previously cited study of Sansom, Wakefield & Yule (1972) on cervical cytology, in which they noted that more working-class women would have had a smear test done had it not been necessary to make an appointment. Thus, in one district of Manchester, out of 600 women who had themselves requested a smear test, no less than 112 failed to keep appointments. Sansom, Wakefield & Yule (1972) noted that 'there is a need for some clinics to try a more flexible approach to the matter, so that women who decide to go for a cytostest may have it performed there and then. The appointment system is tidier for those who have to administer it, but it does not always fit the facts of working-class life... Appointments could still be made, but the woman who calls in should not be turned away.' A number of studies have indicated the difficulties which working-class people have in coping with highly bureaucratized, and indeed highly professionalized, settings and any attempts to de-bureaucratize medical settings may well pay dividends in terms of attracting working-class people to use those services more fully.

A number of other suggestions also arose from the study by Wakefield (1972) and his colleagues. Thus, for example, Sansom (1972) has suggested that cooperation between health services and the management of factories (i.e. in the provision of facilities for cytostests for women employed in the factories) can produce a situation in which the existence of cytostest facilities comes to be seen as a fringe benefit within an industrial context. She notes that once this situation has occurred the 'social logic of fringe benefits now applies' so that local traders unions, for example,
may take up the campaign to extend what are seen as fringe benefits within the context of management-union negotiations.

Communications
A further significant finding reported by Sansom concerns the source of information about cytotox. In response to a question asking respondents to specify how they heard about the tests, women in the upper social classes emphasized the importance of reading and the mass media, whereas lower-class women stressed friends and personal contacts as sources of information. This suggests that for working-class people, the typical mode of exchange of information may be through personal contact and that such a means of communication may be relatively more effective than an impersonal form of communication, such as publicity through advertising. Thus, locally organized campaigns based on personal contact may be a successful way of getting lower-class women to use existing services. Significantly, another study (Davison & Clements 1971) indicates that there may well be a considerable reservoir of women who, having had a cytotox themselves, would be willing to help persuade others to have the test. Davison & Clements (1971) commented that 'with a little encouragement some of these may form a nucleus of volunteers in a community programme'. It may well be worthwhile to consider establishing some such community programmes on an experimental basis, for there are reasons to believe that such programmes may be relatively successful. Thus, not only would the form of communication (word of mouth) be that typically used in working-class communities, but the volunteers would be known and accepted within their own communities, rather than being seen as professional people who are strangers to the community.

One final point emerges from the Wakefield (1972) study, namely that it is clear that much more could be done by GP's to get lower-class patients to use preventive services. Thus, it seems that GP's with predominantly middle-class practices are considerably more likely to take smears than are GP's in working-class practices. One study (Spenser 1969) indicates, however, that a little persuasion by general practitioners, aimed specifically at women in the high-risk groups, can be very effective in reaching these women. Spenser suggests that 'given favourable practice circumstances, a suitably worded letter from the family doctor, reinforced by some verbal persuasion in the course of his daily practice and followed, after two to three months when necessary by a personal visit, is likely to lead to the screening of some 80% of the risk group'. A duplicated letter from the general practitioner, without any follow up, produced a response rate of 40% amongst the high-risk group.

All the ideas discussed so far have been drawn from the Manchester study by Wakefield and his colleagues, and relate specifically to the problems associated with the under use of facilities for cervical smear testing. However, it should be clear that the applicability of these ideas is in no way limited to cervical screening, but that they could be applied to the organization of a wide range of preventive medical services.
MOBILE CLINICS

A remarkably successful experiment in the delivery of health care, namely the mobile health clinic, has been developed and used in the London Borough of Southwark. The Borough of Southwark has a high proportion of old, slum-type housing with a population heavily concentrated into the lower socioeconomic groups, so that the problems of under-utilization in an area of this kind might be expected to be particularly severe. In order to meet these problems, it was decided to take preventive health care out into the community by using a mobile clinic specially equipped to provide a wide range of diagnostic tests. The clinic visited each of the 15 areas of the borough in turn and was parked on sites immediately convenient to the dwellings of those groups at whom the service was aimed. Leaflets explaining the nature of the clinic were distributed to homes in the immediate area, following which a health visitor visited each home giving further information if required and booking appointments on the spot. During the first year, 3160 people were examined in the clinic, but what was particularly impressive was the success of the clinic in attracting people from social classes 4 and 5. The representation of these groups in the population examined by the clinic, paralleled very closely the representation of these groups in the class structure of Southwark as a whole (see Table 4).

<table>
<thead>
<tr>
<th>Social class</th>
<th>Mobile health clinic</th>
<th>Approximate class distribution in Southwark</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>37 (1.2%)</td>
<td>1.6%</td>
</tr>
<tr>
<td>2</td>
<td>544 (17.2%)</td>
<td>7.7%</td>
</tr>
<tr>
<td>3</td>
<td>1341 (42.4%)</td>
<td>52.0%</td>
</tr>
<tr>
<td>4</td>
<td>584 (18.5%)</td>
<td>21.9%</td>
</tr>
<tr>
<td>5</td>
<td>516 (16.3%)</td>
<td>16.2%</td>
</tr>
<tr>
<td>Unclassified</td>
<td>138 (4.4%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3160 (100.0%)</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The then medical officer of health for Southwark noted that most other studies had indicated that persons in social classes 4 and 5 were poor attenders and that in the light of this fact it was particularly heartening to find that nearly 35% of attenders were from social classes 4 and 5. There is little doubt that the introduction of a mobile health clinic for the screening survey has contributed to the high proportion of attendances from the lower socioeconomic groups' (Epsom 1970).

CONCLUSION

Health services are normally provided within organizational settings that are highly-professionalized, highly-bureaucratized and often highly-centralized.
They have, therefore, built into their very structure a bias, in favour of those who are knowledgeable, articulate, socially competent within professionalized and bureaucratized settings, and geographically mobile. These characteristics, however, simply do not fit in with the known facts of working-class life-styles and it is, therefore, hardly surprising that there should be a problem of under-utilization of health services by large sections of the working-class.

I have tried to indicate some possible alternative forms of health care organization. Some of these alternatives might be more easily implemented than others and some would be relatively more expensive than others. Nevertheless, they have one thing in common, they all suggest that we should be more adventurous in the organization of health care services. Again, it should be emphasized that the proposals outlined above are tentative and by no means exhaustive, rather that they have been put forward simply to raise the question of how health services might be organized in such a way as to alleviate the problem of under-utilization by low income groups. The success of the Southwark mobile clinic, in particular, indicates that manual workers and their families will use preventive services if those services are organized in the right way, i.e. in a way which is consistent with working-class life-styles.

References


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Drugs, Sport and Ideologies
IVAN WADDINGTON and PATRICK MURPHY

INTRODUCTION

In November 1989 Steve Pinsent, a British former Commonwealth Games weightlifting champion, was jailed for three months at Aylesbury Crown Court, near London, for supplying anabolic steroids. In passing sentence, Judge Morton Jack told Pinsent (The Times, 18 November 1989) that the use of drugs in sport to improve performances 'is an evil which is prevalent and growing'. Judge Jack's comment nicely points up two of the three interrelated issues which form the subject matter of this paper. The first of these concerns the question of whether the use of drugs in sport is indeed 'prevalent and growing'. The second problem to be examined arises from the fact that what is often described as 'drug abuse' in sport frequently arouses strong and immediate condemnation — as expressed, for example, in Judge Jack's use of the word 'evil' — and that this condemnation is frequently accompanied by demands for swingeing punishments, such as life bans, for athletes found guilty of using prohibited substances. But what is the basis of this opposition to the use of drugs in sport? In seeking to answer this apparently simple question, not from a moralistic but from a sociological perspective, we may be able to shed light on some aspects of the development and contemporary structure of modern sport. The third and final issue of this chapter is to examine some of the major processes, both within sport and within the structure of the wider society, which have been associated with the use of drugs in recent years. In this connection, particular attention will be focused on developments in, and changes in the inter-relationship between, sport and medicine.

THE EXTENT OF ILLICIT DRUG USE IN SPORT

The use by athletes of substances believed to have performance-enhancing qualities is certainly not a new phenomenon. At the Ancient Olympic Games and in Ancient Egypt athletes had special diets and ingested various
substances believed to improve their physical capabilities, whilst Roman gladiators and knights in mediaeval jousts used stimulants after sustaining injury to enable them to continue in combat. In relation to modern sports, swimmers in the 1865 Amsterdam canal races were suspected of taking some form of dope, but the most widespread use of drugs in the late nineteenth century was probably associated with cycling, and most particularly with long distance or endurance events such as the six-day cycle races (Donahoe and Johnson, 1988: 2–3).

It is, of course, impossible to arrive at any very precise estimate of the extent of illicit drug use in contemporary sport for, since the use of many drugs is prohibited under the rules of the International Olympic Committee and other sporting bodies and since the possession of such drugs may also constitute a criminal offence, those who use performance-enhancing substances will almost inevitably seek to do so without being detected. Nevertheless, there are grounds for suggesting that the illicit use of drugs by athletes has increased very markedly in the post-war period and more particularly in the last three decades. This is certainly the view of Donahoe and Johnson who have suggested that the ‘production of amphetamine-like stimulants in the thirties heralded a whole new era of doping in sport’, and they go on to suggest that in recent times ‘a massive acceleration in the incidence of doping in sport has occurred’, a development which in their view is largely associated with further improvements in chemical technology (Donahoe and Johnson, 1988: 2, 4). Mottram (1988: 1–2) dates the increase in drug use from about the same time as Donahoe and Johnson and, perhaps not surprisingly since all three are pharmacists, he attributes it to largely the same causes. Thus he writes: ‘Around the time of the Second World War, the development of amphetamine-like central stimulant drugs reached its peak. . . . Not surprising by the 1940s and 1950s amphetamines became the drugs of choice for athletes.’ He goes on to claim that the ‘widespread use of drugs in sport . . . began in the 1960s’ and, like Donahoe and Johnson, he links this with the ‘pharmacological revolution’ of the 1960s which resulted in the development of more potent, more selective and less-toxic drugs.

Although we cannot know precisely how widespread the use of drugs is amongst sportsmen and -women, it is clear that many people with an intimate knowledge of sport—competitors, coaches, managers and others—are of the view that the use of drugs has increased to the point where it is now very widespread. Perhaps the most striking claim in this respect came from Dr William Standish, the chief physician to the Canadian Olympic team for the Seoul Olympics of 1988. Speaking a few months prior to the Games, Dr Standish (The Times, 7 April 1988) claimed that the ideal of a
drug-free Olympic competition was no longer possible. He claimed: 'We have solid information that the use of drugs to enhance performance is really an epidemic. There is rampant use of anabolic steroids and other performance-enhancing drugs among young athletes. . . . I think we have to look at the traditional Olympic charter and understand that to have a clean Olympics is no longer possible.' John Goodbody, the sports correspondent of The Times and someone who has for several years campaigned against the use of drugs in sport, has claimed (The Times, 28 May 1987) that in weightlifting 'drug-taking has been notorious for years', and that it is now 'more than 20 years since anabolic steroids first became readily available in London gymnasias'. Goodbody also points out (The Times, 27 October 1988): 'Drug-taking in athletics is a widely recognised problem, and in the past 10 years dozens of athletes have been banned from the sport for it. Rumours are rife that many more athletes are taking drugs and that officials are conniving at the practice.' Giving evidence under oath to a Canadian government inquiry following the disqualification of the Canadian sprinter Ben Johnson at the Seoul Olympics, Johnson's coach Charlie Francis (The Times, 2 March 1989) said that the use of drugs in sport was pervasive and that the spiral of record-setting would be impossible without them. When he was chairman of the International Athletics Committee in 1985, Paul Dickenson (The Times, 18 November 1989), a hammer thrower who now works as an athletics reporter for BBC television, estimated that 'sixty per cent of the full range of international athletics events were likely to include some competitors who had taken drugs'.

Outside athletics there have been many drugs scandals involving other sports, with cycling in particular having what Goodbody has called a 'history of deceit'. In 1966 the first five men in the world road race championship all refused to take a drugs test: the five included Jacques Anquetil (The Times, 21 July 1988), five times winner of the Tour de France, who later admitted to taking stimulants and said: 'Everyone in cycling dopes himself and those who claim they do not are liars.'

Whilst many of the most famous drugs scandals – most notably, perhaps, the drugs-related death of the British cyclist Tommy Simpson in the 1967 Tour de France and more recently the disqualification of Ben Johnson at the 1988 Olympics – have involved Western competitors, there have also been persistent rumours for many years alleging the widespread use of drugs amongst East European athletes. Recent evidence from East European sources suggests that there may well be some substance to these rumours. For example, in June 1989 two East Germans, a former Olympic ski-jumping champion and a former sports official who defected separately to
the West, claimed that all East Germans who competed for their country were using drugs. Hans-Juergen Noozenski (The Times, 27 June 1989), the former head of the East German Judo Association, claimed: 'Every athlete that competes internationally for East Germany is doped, every one.' More recently, Sergei Vachekovsky (Independent, 1 December 1989), the Soviet swimming head-coach from 1973 to 1982, has admitted that he personally administered drugs to his swimmers.

One should not, of course, accept without question all such allegations concerning the frequency of drug use in sport, particularly when they are made by people seeking to defend themselves against charges of doping, for such people might seek to exaggerate the degree of drug use in an attempt to mitigate their own offence, for example by claiming that what they did was only 'normal practice'. Nevertheless, it is suggested that allegations of the kind outlined above have to be given some credibility for a variety of reasons. The first of these relates to the sheer number of such allegations, those cited above constituting just a small proportion of the very many similar allegations which have been made in recent years. The second consideration relates to the fact that broadly similar allegations have come from a wide variety of sources — that is to say, from competitors, coaches, managers, doctors and sports commentators, from a wide variety of sports and from a number of different countries — and many of those who have made such allegations are widely respected both for their knowledge of sport and for their integrity; indeed, several of those who have made such allegations have been in the forefront of the campaign against the use of drugs in sport. The third and final consideration relates to relatively "hard" evidence in the form of the results of testing for drug use by athletes.

At an international conference on doping in sport held in June 1989, Professor Raymond Brooks revealed that during 1987 he had tested a number of urine samples from sportsmen competing in Britain. The test was for a particular drug, human chorionic gonadotrophin (HCG), a hormone drug which raises the level of testosterone, so helping a competitor to recover more quickly from intensive exercise. HCG was not banned by the International Olympic Committee until 1989, and prior to this time there were reports that competitors stopped taking anabolic steroids a month before an event in order to avoid detection, and switched safely to HCG for the last few weeks of preparation. Professor Brooks indicated that, of 740 samples tested, 21 samples taken from thirteen sportsmen had proved positive. It should be emphasized that the test was not designed to identify a wide range of drugs but just HCG, and Professor Brooks concluded that the results of his tests indicated 'a very high rate of abuse of a single drug'.
Professor Arnold Beckett (*The Times*, 7 June 1989), a leading member of the IOC medical commission concurred, arguing that ‘According to these facts ... then at least in the UK there is a serious problem’.

On an international level, the most recent large-scale testing for drug use by athletes came at the 1988 Seoul Olympic Games. The most celebrated drugs scandal at the Games was, of course, that involving Ben Johnson who was disqualified after failing a drugs test following his victory in the 100 metres. In addition to Johnson, nine other competitors were banned during the Games for taking drugs. Clearly, however, these ten represented only the tip of a much larger iceberg. Before the start of the Games, four Canadian weightlifters were pulled out because they were found to have taken anabolic steroids, whilst three more weightlifters, two from Egypt and one from Iraq, were also found positive in the random pre-Games testing. In addition, three Tunisians refused to undergo tests. In the Games themselves, two Bulgarian gold-medal-winning weightlifters were disqualified, following which the whole of the Bulgarian team — the premier force in the sport in recent years — was withdrawn. Following these events, the International Weightlifting Federation announced that it was to launch its own investigation into drug-taking in an attempt to restore the credibility of the sport (*The Times*, 26 September and 3 October 1988).

Further evidence that illicit drug use was much more widespread than the ten suspensions during the Games would suggest came from research involving the retesting of urine samples taken from 1100 male competitors at the Games. The retesting was carried out some time after the Games by Professor Manfred Donike, one of the world’s leading authorities on drug abuse, and the results, which were accepted by the IOC medical commission, indicated that more than 50 competitors had used anabolic steroids during training. No action could be taken against the athletes concerned because the names identifying the athletes’ samples are destroyed after the Games (*The Times*, 28 August 1989).

Although none of this evidence is sufficiently conclusive to enable us to make very precise statements about trends in, and current levels of, illicit drug use in sport, the evidence does strongly suggest, first, that there has been a significant increase in the level of drug use particularly in the last three decades or so; and second, that the illicit use of drugs is now by no means uncommon; indeed there is no reason to disagree with Professor Beckett’s view that the use of drugs is now sufficiently common for it to constitute a ‘serious problem’.
THE ACHIEVEMENT OF PROBLEM STATUS

The characterization of illicit drug use in sport as a 'serious problem' does however immediately raise the question of why the use of drugs to enhance sporting performance is seen as a 'problem'. Speaking at the Olympic Congress in 1981, Sebastian Coe, the 1500 metres gold medallist in the 1980 Games, said: 'We consider this [doping] to be the most shameful abuse of the Olympic ideal: we call for the life ban of offending athletes; we call for the life ban of coaches and the so-called doctors who administer this evil' (see Donohoe and Johnson, 1988: 1). Why should the use of drugs evoke from many people within the world of sport such strong condemnation, coupled with demands for swingeing punishments for those found to be using drugs?

The two most usual grounds for objecting to the use of drugs in sport are clearly set out in a leaflet entitled Doping Control in Sport: Questions and Answers, published in Britain by the Sports Council in 1987. In this leaflet, the Sports Council set out their objections to the use of drugs in the following terms:

Drugs and other substances are now being taken not for the purposes they were intended [sic], but simply to attempt to enhance performances in sport. It puts the health of the athlete at risk. It can be dangerous. It undermines the foundation of fair competition. It is cheating. (Italics in original)

The position could hardly be stated more clearly. The Sports Council is opposed to the use of drugs, first, because it may be damaging to health, and secondly, because it is a form of cheating. It may be useful to consider each of these objections in turn.

The first objection — that the use of drugs may be harmful to health — is considerably elaborated in another, undated, leaflet produced by the Sports Council, entitled Dying to Win. The leaflet contains on the front cover a health warning reminiscent of the government health warning on cigarette packets: 'Warning by the Sports Council: taking drugs can seriously damage your health'. The leaflet details some of the side-effects which, it claims, are associated with the use of stimulants, narcotic analgesics and anabolic steroids, and refers on several occasions to the possibility of death as a result of drug abuse. The leaflet concludes by advising coaches, teachers and parents to 'warn athletes of the great dangers of these drugs. . . . Tell them that by taking drugs, what they would be doing would literally be DYING TO WIN.'
It might be noted that bodies such as the Sports Council have recently been accused of exaggerating the health risks associated with drugs such as anabolic steroids (The Times, 18 September 1987). However, it is not our intention to become embroiled in this debate. Our concerns are sociological rather than pharmacological and, as such, our aim here is not to evaluate the validity of these pharmacological arguments about drugs and health but to locate that debate within the context of broader social processes.

That at least part of the objection to the use of drugs should rest upon grounds of health is, perhaps, not altogether surprising, for as Goudsblom (1986: 181) has pointed out: 'in the twentieth century, concern with physical health has apparently become so overriding that considerations of hygiene have gained pride of place among the reasons given for a variety of rules of conduct'. Moreover, this is the case even where – as is by no means uncommon – those rules had, at least in the first instance, little or nothing to do with considerations of health. This point may, perhaps, be most clearly illustrated by reference to the work of Norbert Elias on which Goudsblom has drawn.

In The Civilizing Process Elias analyzes the development and elaboration over several centuries of a variety of rules of conduct relating to bodily functions such as eating, drinking, nose-blowing and spitting. In relation to the way in which such bodily functions are managed, Mennell has noted that, since the way in which these functions are performed clearly has important implications for health, there is a tendency on our part to assume that these functions must have been regulated largely in the interests of health and hygiene. As Mennell (1986: 46) puts it, to

the modern mind it seems obvious that considerations of hygiene must have played an important part in bringing about higher standards. Surely the fear of the spread of infection must have been decisive, particularly in regard to changing attitudes towards the natural functions, nose-blowing and spitting, but also in aspects of table manners such as putting a licked spoon back into the common bowl?

In fact, however, as Elias (1978: 115–16) demonstrates, a major part of the controls which people have come to impose upon themselves has not the slightest connection with 'hygiene', but is concerned primarily with what Elias calls 'delicacy of feeling'. Elias's argument is that over a long period and in conjunction with specific changes in human relationships, the structure of our emotions, our sensitivity – our sense of shame and delicacy – also changes, and these changes are associated with the elaboration of
controls over the way in which bodily functions are carried out. It is only at a later date that these new codes of conduct are recognized as 'hygienically correct', though this recognition may then provide an additional justification for the further elaboration or consolidation of these rules of conduct.

In many respects Elias's analysis provides a good starting point for a re-examination of the debate about sport, drugs and health. Could it be that what Elias argues in relation to codes of conduct relating to such things as nose-blowing or spitting or washing one's hands is, at least in some respects, also applicable to a rather different set of rules of conduct, namely, those relating to the use of drugs in sport? In other words, is the ban on the use of certain drugs in sport based primarily on a concern for the long-term health of athletes? Or is it the case that the arguments about health are essentially secondary or supporting arguments which, because of the cultural status of medicine and the value generally placed upon health, lend particularly useful support to a code of conduct which is based primarily on considerations having little, if anything, to do with health? We do not claim to be able to provide a definitive answer to this problem. However, a preliminary exploration of this question is worthwhile, not least because it raises a number of other interesting problems concerning the relationship between sport and health.

THE LIMITS OF THE HEALTHY BODY ETHOS

If the concern for health constitutes the principal objection to the use of drugs in sport, then we might reasonably expect a similar concern for health to inform other aspects of the organization of sport. Is this in fact what we find? It is undoubtedly the case that, at least at an ideological level, there is a strong link between sport and health. The idea that sport is health-promoting and even life-enhancing is one which is frequently stressed by those involved in sport — to quote Sebastian Coe (foreword to Mottram, 1988): 'Sport is an integral part of a healthy lifestyle in today's society.' Though the ideology linking sport and health is a very powerful one — and one which is probably widely accepted — an examination of certain aspects of the organization of sport casts some doubt on the assumed closeness of the relationship between sport and the promotion of healthy life-styles. From amongst several relevant features of modern sport which could be examined, we limit ourselves, for reasons of space, to just two: namely, sponsorship in sport and the widespread but legal use of drugs for the management of sports-related conditions.
Perhaps the area which casts doubt most publicly on the assumed relationship between sport and the promotion of healthy life-styles is that of sports sponsorship. In the 1970s overall business sponsorship of sport and the arts in Britain grew at around 20 per cent a year, from £15 million in 1973 to over £50 million by 1981. Roughly 90 per cent was spent on sports and the rest on the arts, with the tobacco companies being by far the biggest spenders (Taylor, 1985: 99). Sports sponsorship is a relatively cheap and highly cost-effective means of advertising for the tobacco companies, not least because in Britain it enables them to circumvent the 1965 ban on the advertising of cigarettes on television; in 1981 three of the four top sporting events which gained most television exposure were sponsored by tobacco companies, these being the Embassy and State Express snooker tournaments and John Player cricket (Taylor, 1985: 103). Sponsorship of sporting events by tobacco companies is now very widespread; amongst the sports sponsored in Britain are motor racing, powerboat racing, cricket, speedway, snooker, darts, bowls, horseracing, tennis, rugby union, rugby league, badminton, show-jumping, motor-cycling and table-tennis.

Sponsorship of sporting events by the tobacco companies is, of course, not confined to Britain. In 1982 Dr Thomas Dadour introduced in the Western Australian Parliament a bill to ban all forms of cigarette advertising and promotion. Had the bill been passed, one of the first casualties would have been the advertising at the Australia versus England Test Match, which was sponsored by Benson and Hedges who have been the Australian Cricket Board’s main sponsor for more than ten years. The bill was narrowly defeated. The following year, the state government of Western Australia introduced another bill similar to Dr Dadour’s. This bill was also defeated following intensive lobbying by, amongst others, those associated with the cigarette-sponsored sports under threat (Taylor, 1985: 48–9).

Such sponsorship would not, at least in the context of the present argument, be of any significance were it not for the fact that, by the early 1980s, cigarette smoking was estimated to be responsible for more than 300,000 premature deaths a year in the US, and nearly half a million deaths a year in Europe. In a 1982 report the US Surgeon-General described cigarette smoking as ‘the chief, single, avoidable cause of death in our society, and the most important public health issue of our time’, whilst in Britain the Royal College of Physicians, in their 1971 report Smoking and Health Now referred to the annual death-rate caused by cigarette smoking as ‘the present holocaust’ (Taylor, 1985: xiv, xvii). Without labouring the point, one might reasonably suggest that the ideology which associates sport with healthy life-styles sits uneasily with the widespread acceptance of sports sponsorship by tobacco companies.
The issue of whether the banning of certain drugs in sport reflects a primary concern with health issues may, however, be approached rather more directly. In particular, a brief examination of the use of several drugs which are not banned and which are widely used in the treatment or management of sports-related conditions is quite revealing.

One of the most common sights in many sports is that of the trainer running on to the field of play to treat an injured player, often by the application of an aerosol spray to a painful area, thereby enabling the player to continue. However, as Donahoe and Johnson (1988: 94) point out, one of the functions of pain is to "warn" us that we need to rest the damaged area", and they suggest that most athletes and coaches "fail to recognize the damage that can be caused by suppressing pain". This issue is part of the more general concern about overuse injuries, a growing problem which is clearly associated with the increasing constraints placed upon sportsmen and women to compete and more particularly to win with, one suspects, often scant concern for the potential longer-term health risks. It has been noted (Donahoe and Johnson, 1988: 93) that, "To succeed in modern sport, athletes are forced to train longer, harder, and earlier in life. They may be rewarded by faster times, better performances and increased fitness, but there is a price to pay for such intense training." Part of the price of such intense training and of the readiness - often encouraged by coaches and medical advisers - to continue training and competing despite injury, is unquestionably paid in the form of overuse injuries, which are now a serious problem. It should also be noted that, as Donahoe and Johnson (1988: 93) point out, the 'long-term effects of overuse injuries are not known, but some concerned doctors have asked whether today's gold medallists could be crippled by arthritis by the age of 30', and they cite examples of world-class competitors who have, in their words, 'been plagued by a succession of overuse injuries'.

It is, however, not simply the problem of overuse injuries which is of relevance. Since, as we have seen, part of the case against the use of drugs such as anabolic steroids rests on the possible health risks associated with those drugs, it is of some interest to note that several drugs which are very widely - though perfectly legally - used within sport also have a variety of potentially serious side-effects. Prominent amongst these drugs are several painkillers. Injections of local anaesthetic drugs, for example, can produce cardiac disorders and should not be used 'on the field'. In very large doses they cause central nervous system stimulation, convulsions and death. The IOC permits the use of local anaesthetics only where there is 'medical justification' - by which is presumably meant only where there is an injury which would otherwise prevent a competitor from taking part - and 'only
with the aim of enabling the athlete to continue competing' (Donahoe and Johnson, 1988: 95). One might reasonably ask whether these regulations express a primary concern for the health of the athlete or whether considerations relating to the value of competition are ranked more highly?

Several painkilling drugs which are widely used for the treatment of sports injuries are known to have a variety of side-effects, with prolonged use leading to possible gastrointestinal effects such as ulceration or perforation of the stomach or intestines, whilst diarrhoea is a commonly reported side-effect. In addition to effects on the liver and blood cells, they also affect the central nervous system causing headaches, dizziness or disorientation. Most concern has, perhaps, been expressed about the use of phenylbutazone, commonly known as 'bute'. Introduced in 1949 for the treatment of arthritis, phenylbutazone is a powerful anti-inflammatory drug which has a large number of toxic side-effects, some of which have had fatal outcomes. The most serious side-effects are the retention of fluid, which in predisposed individuals may precipitate cardiac failure, and interference with normal blood cell production most commonly resulting in aplastic anaemia and agranulocytosis which can occur within the first few days of treatment. A Washington consumer group recently called for bans on phenylbutazone and another anti-inflammatory drug, oxyphenbutazone, claiming that their side-effects may have led to 10,000 deaths worldwide. Many physicians argue that phenylbutazone is too dangerous to use for the treatment of self limiting musculoskeletal disorders, and in Britain it is now indicated only for use in hospitals under careful supervision. However, in the US it is still widely used in the sports context to reduce pain and swelling in joints and ligaments, most notably in the National Football League (Donahoe and Johnson, 1988: 97; Elliott, 1988: 103). Phenylbutazone is not on the list of drugs banned by the IOC.

From what has been said it is clear that, whilst there may indeed be potentially dangerous side-effects associated with the use of certain banned drugs, much the same may also said about many drugs which are not banned and which are widely used within the sporting context. The fact that several potentially dangerous drugs are used perfectly legally within sport suggests that – whatever the ideological rhetoric linking sport and health – considerations of health may not constitute the primary basis underlying the decision to ban certain drugs but not others. To return to the question raised earlier, could it be the case that health considerations – though they may not be entirely irrelevant – provide a convenient and useful but essentially secondary justification for a ban which rests primarily on other values having little or nothing to do with health? If this is the case, then what might these other values be?
‘FAIR PLAY’ VERSUS ‘CHEATING’

It will be recalled that the Sports Council, in the leaflet cited earlier, give a second reason for their opposition to the use of drugs, namely, that using drugs ‘undermines the foundation of fair competition’. In a word, it is cheating, and it is this, we suggest, rather than a concern for health, which constitutes the primary objection to the use of drugs. That this is so is suggested by the relatively tolerant attitude taken by many sporting bodies towards the ‘social’ use of drugs such as marijuana and cocaine, the latter of which may have potentially dangerous side-effects and both of which — unlike many of the drugs banned by the IOC — are illegal in many countries.

Let us consider first the case of marijuana. Prior to the Seoul Olympic Games the IOC was asked by several countries to test for marijuana ‘to see whether there was a problem among top-class competitors’. A small number of competitors were found to have smoked marijuana recently. The possession of marijuana is a criminal offence in Korea, but the names of the athletes involved were not released because cannabis is not banned by the IOC. In the words of the president of the IOC’s medical commission: ‘Marijuana does not affect sporting performance.’ A similar position was expressed by Professor Arnold Beckett (The Times, 14 September 1988), another leading member of the IOC medical commission, who argued that ‘If we started looking at the social aspect of drug-taking then we would not be doing our job.’

Some sporting bodies — it should be noted that not all sporting bodies have the same rules in this respect — appear to have taken a similar position in relation to the use of cocaine which, though technically a stimulant and therefore on the list of drugs banned by the IOC, is also very widely used for ‘recreational’ purposes. It is presumably the latter consideration which has led the tennis authorities at the Wimbledon Championships to adopt a relatively tolerant attitude towards tennis players found to be using cocaine. Thus in 1986 it was revealed (see The Times, 14 September 1986) that tests for cocaine were to be carried out on male tennis players at Wimbledon, although no action would be taken against those who tested positive; instead, psychiatric help would be offered.

What we are suggesting, therefore, is that the major basis of differentiation between those drugs which are banned and those which are not banned is to be found not in the fact that the former pose a threat to health whilst the latter do not — such an argument, we would suggest, is exceedingly difficult to sustain — but in the fact that the former are perceived as being taken in order artificially to boost performance, thereby giving the competitor who uses drugs an unfair advantage over those who do not. The more fundamen-
tal objection to the use of drugs, then, lies in the fact that, in the words of the Sports Council, ‘it is cheating’.

But why should the practice of cheating be regarded as so objectionable? Why should drug-taking evoke calls for swingeing punishments against those who are tested positive? At first glance the answer may seem self-evident, for such is the strength of feeling against cheating that we might be tempted to think that the idea of cheating ‘naturally’ arouses strong hostility. The matter is, however, considerably more complex than this, for an analysis of the development of the concept of cheating and of the associated notion of ‘fair play’ raises some interesting questions about the civilizing process and the development of modern sport.

It is essential to see the development of concepts such as ‘cheating’ and ‘fair play’ as an integral part of the development of a broader configuration of relationships. More specifically the development of these concepts – at least in the sense in which they are used within modern sport – can be seen as part of that process which Elias has termed ‘sportization’. Though the concept of ‘sportization’ may jar upon the ear it does, as Elias notes, fit the observable facts relating to the development of modern sports quite well. Elias’s (1986: 151) argument is that, in the course of the nineteenth century – and in some cases as early as the second half of the eighteenth century – with England as the model-setting country, some leisure activities involving bodily exertion assumed the structural characteristics which we identify with modern sports. A central part of this ‘sportization’ process involved the development of a stricter framework of rules governing sporting competition. Thus the rules became more precise, more explicit and more differentiated whilst, at the same time, supervision of the observance of those rules became more efficient; hence, penalties for offences against the rules became less escapable. One of the central objectives – perhaps the central objective – of this tightening up of the rules was to ensure that sporting competitions were carried on with proper regard for what we call ‘fairness’, the most important element of which is probably the idea that all competitors must have an equal chance of winning. As part of the ‘sportization’ process, the idea of ‘fairness’ – and therefore the abhorrence of cheating – has come to be regarded as perhaps the most fundamental value underpinning modern sporting competitions. In this context one might, for example, compare the relatively highly rule-governed character of modern sports with the relative absence of rules governing many traditional folk-games in pre-industrial Europe, many of which had few, if any, rules governing such things as physical contact or even the number of players permitted on each side (Dunning and Sheard, 1979: ch. 1). The importance
of the sportization process and its relationship to the concept of cheating may be brought out very simply: where there are no rules one cannot cheat. The development of the concept of cheating, therefore, is closely associated with the development of a body of relatively clearly defined rules; in this sense, the development of our modern concepts of 'cheating' and of 'fair play' can only be adequately understood as part of the sportization process to which Elias has drawn our attention.

Thus far we have examined some of the evidence relating to the use of drugs in sport, and we have considered some of the social processes underpinning specific objections to the illicit use of drugs. We now turn to our third and final problem; namely, how do we account for what, as we noted earlier, does indeed appear to have been a significant increase in the use of drugs in sport in recent years? In order to shed some light on this issue, it is necessary to examine recent developments not merely in sport but also in medicine. We begin with the latter.

THE MEDICALIZATION OF LIFE

In an influential essay published in 1972, Irving Zola (1972: 487) argued that in modern industrial societies medicine is becoming a major institution of social control. This process, he argued, was a largely insidious and often undramatic one which was associated with the 'medicalizing' of much of daily living, a process which involves 'making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence'. The medicalization process has involved an expansion of the number and range of human conditions which are held to constitute 'medical problems', a label which, once attached, is sufficient to justify medical intervention. Zola cites four such problems: ageing, drug addition, alcoholism and pregnancy, the first and last of which were once regarded as normal processes and the middle two as human foibles and weaknesses. This has now changed and medical specialities have emerged to deal with these conditions, one consequence of which has been to expand very considerably the number of people deemed to be in need of medical services. A similar process has occurred as a result of the development of 'comprehensive' and psychosomatic medicine, both of which have considerably expanded that which is held to be relevant to the understanding, treatment and prevention of disease. The development of preventive medicine, in particular, has justified
increasing medical intervention in an attempt to change people's lifestyles, whether in the areas of diet, sleep, work, marital relationships, exercise, tobacco and alcohol consumption, or in the areas of safer driving or the fluoridation of water supplies.

The theme of the medicalization of life has subsequently been taken up by a number of other writers. Waitzkin and Waterman (1974: 86–9), for example, have attempted to analyze this process in terms of what they call 'medical imperialism'. However, perhaps the most famous thesis of this kind is that associated with Ivan Illich. Illich argues that the medicalization of life involves a number of processes, including growing dependence on professionally provided care, growing dependence on drugs, medicalization of the life-span, medicalization of prevention and medicalization of the expectations of lay people. One of the consequences has been the creation of 'patient majorities' for, argues Illich (1975: 56), people 'who are free of therapy-oriented labels have become the exception'. Large numbers of people are now regarded as requiring routine medical attention, not because they have any definable pathology, but 'for the simple fact that they are unborn, newborn, infants, in their climacteric, or old' (Illich, 1975: 44). In other words, the expansion of that which is deemed to fall within the province of medicine has expanded to the point where, as de Swaan (1988: 243) puts it, 'there remain only patients and those not yet patients'.

Although several of those involved in developing the medicalization thesis have made some pertinent observations on recent social developments relating to medicine, it is probably fair to say that, on the whole, these analyses have not involved a great deal of theoretical sophistication, whilst some — the work of Waitzkin and Waterman and, even more so, that of Illich comes to mind here — are notable for their polemical character and their relative lack of detachment. The early essay of Zola (1972: 487) is in many respects more satisfactory, though it is largely descriptive, and his analysis of the process — that it 'is rooted in our increasingly complex technological and bureaucratic system' — is too vague to be of any real value. In this respect, we would suggest that de Swaan's work, which draws upon the work of Elias, is particularly valuable. Specifically we would argue that it is his use of an Eliasian framework which enables de Swaan to make a series of relatively precise and very fruitful connections between the medicalization process — or what he calls the reluctant imperialism of the medical profession and the collectivizing of welfare services, state formation and development and the civilizing process. Though we cannot here enter into a detailed consideration of de Swaan's work — this would take us on a lengthy detour away from the main subject matter of this chapter — we suggest that de Swaan's analysis offers considerably more, by way of
explanatory purchase, than do the other approaches outlined above, and that it provides further evidence of the fruitfulness of an Eliasian approach.

It is an important part of our argument that, particularly in the last three decades or so — very roughly, the period coinciding with the most rapid growth in the illicit use of drugs — the medicalization process has encompassed sport. This process has been most evident in the rapid development, particularly since the early 1960s, of what is now called sports medicine, an area of practice which has been described by two of the leading British exponents (Williams and Sperryn, 1976: ix) as 'an integrated multidisciplinary field embracing the relevant areas of clinical medicine (sports traumatology, the medicine of sport and sports psychiatry) and the appropriate allied scientific disciplines (including physiology, psychology and biomechanics).

Some of the processes involved in the medicalization of sport — and in particular the development of an ideology justifying increasing medical intervention — can be illustrated by reference to textbooks in the area of sports medicine. This ideology is clearly expressed in one of the early British texts in the field — J. G. P. Williams's *Sports Medicine*, published in 1962 — in which the author argues that the intensity and diversity of modern competitive sport 'has resulted in the emergence from the general mass of the population of a new type of person — the trained athlete'. Williams goes on to argue — some may feel not very convincingly — that the trained athlete 'is as different physiologically and psychologically from “the man in the street” as is the chronic invalid'. This argument is, however, important in establishing a justification for medical intervention, for he goes on to suggest: 'Just as extreme youth and senility produce peculiar medical problems, so too does extreme physical fitness' (Williams, 1962: vii). One can see here the development of the idea, now very widespread, that athletes require routine medical supervision not because they necessarily have any clearly defined pathology but, in this case, simply because they are athletes. This position is, in fact, spelt out quite unambiguously in the foreword to Williams's book by Arthur (later Lord) Porritt, who was at that time the president of the Royal College of Surgeons of England and the chairman of the British Association of Sport and Medicine. Porritt’s (in Williams, 1962: v) position could hardly have constituted a clearer statement of what is involved in the medicalization process, for he argued quite boldly that ‘those who take part in sport and play games are essentially patients’. Athletes have thus become yet one more group to add to Illich’s list of those — the unborn, newborn, infants and so on — who are held *by definition* to require routine medical supervision, irrespective of the presence or absence of any specific pathology.
One consequence of the development in recent years of the discipline of sports medicine, and of closely associated disciplines such as exercise physiology, biomechanics and sports psychology, has been to make traditional methods of training for sporting events increasingly outmoded. At least at the higher levels of sport, both amateur and professional, the image of the dedicated athlete training alone or with one or two chosen friends no longer corresponds to reality. Instead, the modern successful athlete is likely to be surrounded by — or at least to have access to — and to be increasingly dependent upon, a whole group of specialist advisers, including specialists in sports medicine. Moreover, this dependence on those who practise sports medicine goes far beyond the treatment of sports injuries; as Williams and Sperryn (1976: 1) point out, as 'practice for the competitive event takes place ... sportsman [sic] seeks systematic methods of preparation. He examines such technical and scientific information as is available about the way his body performs its athletic function and turns to the doctor as physiologist.' One consequence of these developments has been to make top-class athletes more and more dependent on increasingly sophisticated systems of medical support in their efforts to run faster, to jump further or to compete more effectively in their chosen sport. As the former Amateur Athletics Association national coach, Ron Pickering, notes in his foreword to Sperryn's Sport and Medicine (1983: vi), few would deny that 'nowadays medical support is essential for the realization of the athlete's natural capacity for optimum performance'; indeed, at the highest levels of competition the quality of the medical support may make the difference between success and failure. Just how sophisticated modern systems of medical back-up have become is illustrated by Pickering's admittedly tongue-in-cheek comparison between the limited amount of scientific knowledge which was available to coaches at the start of his career and the vast amount of knowledge which has subsequently been gained from experiments on athletes 'who have given blood, sweat, urine, muscle biopsies and personality inventories, have often been immersed in tanks, and photographed naked in three dimensions at altitude'.

It would, however, be quite wrong to suggest that athletes are simply unwilling 'victims' of medical imperialism for, as de Swaan (1988: 246) has noted, professionals — in this instance, doctors — 'do not simply force themselves with innocent and unknowing clients'. In the case of sport, a number of developments, particularly in the post-Second World War period, have led sportsmen and -women increasingly to turn for help to anyone who can hold out the promise of improving their level of performance. The most important of these developments are probably those which have been associated with the politicization of sport, particularly at the international
level, and those which have been associated with massive increases in the rewards — particularly, but not exclusively, the material rewards — brought by sporting success. Both these processes, it is suggested, have had the consequence of increasing the competitiveness of sport, and one aspect of this increasing competitiveness has been the downgrading, in relative terms, of the traditional value associated with taking part whilst greatly increasing the value attached to winning.

Although the trend towards the increasing competitiveness of sport has been particularly marked in the post-1945 period, the trend itself is a very much longer-trend which can be traced back over two or more centuries and which has been associated with the processes of industrialization and state development. Before we examine the relatively recent developments associated with the politicization and commercialization of sport, it may be useful to outline briefly the social roots of this longer-term trend towards the increasing competitiveness of sport or, what is the same thing, towards the 'de-amateurization' of sport.

THE 'DE-AMATEURIZATION' OF SPORT

The long-term trend towards the increasing competitiveness of sport is a good example of what Elias (1987: 99–100) calls a 'blind' or 'unplanned' long-term social process; that is, this trend is not the intended outcome of the acts of any single individual or group but, rather, the unintended outcome of the interweaving of the purposive and often conflictual actions of the members of many interdependent groups over several generations. In his analysis of the 'de-amateurization' of sport, Dunning (1986: 205–23), drawing upon an earlier paper by Elias and himself (Elias and Dunning, 1966), argues that the overall social figuration of pre-industrial Britain was not conducive to the generation of intense competitive pressure in sporting relations. The relatively low degree of state centralization and national unification, for example, meant that 'folk-games', the games of the ordinary people, were played in regional isolation, competition traditionally occurring between adjacent villages and towns or between sections of towns. There was no national competitive framework. The aristocracy and gentry formed a partial exception in this respect for they were, and perceived themselves as, national classes and did compete nationally among themselves. However, their high degree of status security — that is, their power and relative autonomy — meant that the aristocracy and gentry were not subject, in a general or a sporting sense, to effective competitive pressure
either from above or below. As a result, the aristocracy and gentry, whether playing by themselves or with their hirelings, were able to develop what were to a high degree self-directed or egocentric forms of sports participation; put more simply, they were able to participate in sport primarily for fun and, in this sense, came close to being amateurs in the 'ideal-typical' sense of that term.

Dunning argues that the growing competitiveness of sporting relations since the eighteenth century has been associated with the development of the pattern of inter-group relationships characteristic of an urban-industrial nation-state. Inherent in the modern structure of social interdependencies, he suggests, is the demand for inter-regional and representative sport. Clearly no such demand could arise in pre-industrial societies because the lack of effective national unification and poor means of transport meant that there were no common rules and no means by which sportsmen from different areas could be brought together. In addition, the 'localism' inherent in such societies meant that play-groups perceived as potential rivals only those groups with which they were contiguous in a geographical sense. However, modern industrial societies are different on all these counts. They are relatively unified nationally, have superior means of transport and communication, sports with common rules, and a degree of 'cosmopolitanism' which means that local groups are anxious to compete against groups which are not geographically contiguous. Hence such societies come to be characterized by high rates of inter-area sporting interaction, a process which leads to a hierarchical grading of sportsmen, sportswomen and sports teams with those that represent the largest social units standing at the top.

Dunning suggests that one consequence of these processes is that top-level sportsmen and -women are less and less able to be independent and to play for fun, and are increasingly required to be other-directed and serious in their approach to sport. That is, they are less able to play for themselves and are increasingly constrained to represent wider social units such as cities, counties and countries. As such, they are provided with material and other rewards and facilities and time for training. In return, they are expected to produce high-quality sports performances which, particularly through the achievement of sporting victories, reflect favourably on the social units which they represent. The development of the local, national and international competitive framework of modern sport works in the same direction and means that constant practice and training are increasingly necessary in order to reach and to stay at the top. In all these ways, then, the social figuration characteristic of an urban-industrial nation-state increasingly undermines the amateur ethos, with its stress on sport 'for fun', and leads to
its replacement by more serious and more competitive forms of sporting participation.

THE POLITICIZATION OF SPORT

Although the relationship between politics and sport is by no means exclusively a post-World War Two phenomenon — witness the Munich Olympics of 1936 — there can be little doubt that sport has become increasingly politicized in the period since 1945. To some extent, this process has perhaps been associated with the development of independent nation-states in Black Africa and elsewhere and with the emergence in many of those states of several outstanding athletes whose international successes have been a major source of pride in new nations struggling to establish a national identity and a sense of national unity.

Of rather greater importance, however, was the development — although they have recently begun to change in fundamental but as yet uncertain ways — of state socialist societies in many parts of Eastern Europe and, associated with this, the emergence of the Cold War and of superpower rivalry. Within this context, international sporting competition took on a significance going far beyond the bounds of sport itself, for sport — at least within the context of East-West relations — became to some extent an extension of the political, military and economic competition which characterized relationships between the superpowers and their associated blocs. Thus comparisons of the number of Olympic medals won by the United States and the Soviet Union or the medals won by the two Germanies took on a new significance, for the winning of medals came to be seen as a symbol not only of national pride but also of the superiority of one political system over another. As many governments came to see international sporting success as an important propaganda weapon in the East-West struggle, so those athletes who emerged as winners came increasingly to be treated as national heroes with rewards — sometimes provided by national governments — to match.

SPORT AND COMMERCIALIZATION

If the politicization of sport has been associated with an increase in the competitiveness of international sport, this latter development has also been
facilitated by the growing commercialization of sport in the West. Whilst the winning of an Olympic medal has doubtless been considered a great honour ever since the modern Olympics were founded in 1896, it is indisputably the case that in recent years the non-honorific rewards – and in particular the financial rewards – associated with Olympic success have increased massively. For example, successful athletes are not only in a position to demand substantial appearance fees for competing in major meetings but, much more importantly, they can also earn huge incomes from sponsorship, from television commercials and from product endorsement. Although this development appears to be a fairly general one within Western societies, the financial rewards associated with Olympic success are probably greatest in the United States. Dr Robert Voy (On the Line, 1990) the chief physician to the US team at the 1988 Seoul Olympics, recently estimated that in the US the average Olympic gold medal was worth around $1 million in sponsorship, television advertisements and product promotion. He went on to point out, however, that such fabulous rewards are available only to those who come first for, as he put it, 'second place doesn't count'.

As the rewards to be gained from sporting success have increased, so the emphasis placed on winning has also increased. This process has, according to the leading US athletics coach, Brooks Johnson (On the Line, 1990), resulted in a situation in which many top-class international athletes ‘wake up with the desire and the need and the compulsion and the obsession to win, and they go to sleep with it. ... Make no mistake about it, an Olympic champion is clinically sick.’ A not-dissimilar point has been made by Angella Issajenko, a world-record-holder over 50 metres indoors who, like Ben Johnson, was coached by Charlie Francis and who, also like Johnson, has recently admitted to taking steroids. Issajenko (The Times, 14 March 1989) said she took the decision to use steroids after being beaten by East German sprinters and, in explaining her decision (‘On the Line’, 1990), she said that most people ‘had no idea of what goes on in the mind of an elite athlete. Nobody wants to be mediocre. Nobody wants to be second best.’

The importance which has become attached to winning was particularly clearly expressed in an interview with Zoe Warwicke, a former British bodybuilding champion, following the disqualification of Ben Johnson at the Seoul Olympics. Although bodybuilding is not officially recognized as a sport, it may be regarded as a sport-like activity which has much in common with sport, not least, it would seem, in terms of the importance attached to winning. Commenting on Johnson’s disqualification, Warwicke (The Times, 29 September 1988), who admits to having used anabolic
steroids, said: 'I am not going to say whether Johnson did right or wrong. He did what he thought was necessary to win for both his country and himself and I empathize with that.' Speaking of her own use of steroids, Ms Warwicke, who is reported to suffer from kidney and liver disorders as a result of her use of the drugs, said that she does not regret taking them and would do so again under medical supervision for 'that one moment of glory, that feeling of being blessed all athletes seek'. The experience of winning was, she said, 'the best high you can have in life. The moment I won the national championship elevated me into something else for ten minutes or so. Just to win made it worth all the pain.' Warwicke almost certainly echoed the sentiment of a great many athletes when she said: 'I would not want to compete unless I had a chance of winning', and she went on to suggest: 'What we are asking athletes to do is very unfair. We are asking them to get slapped for being clean and losing. No one remembers losers even if they were clean of drugs.'

THE SPORT/MEDICINE AXIS

At this stage it might be useful to summarize briefly our argument thus far. We have suggested that what appears to be a significant increase in the illicit use of drugs in recent years has been associated with two major processes. The first of these relates to what has been called the 'medicalization of life' or 'medical imperialism', whilst the second relates to the increasing competitiveness of sport and to a growing emphasis on the importance of winning. More specifically, it is suggested that certain developments within the medical profession have meant that medical practitioners have been increasingly prepared to make their professional knowledge and skills available to athletes at the very time when athletes, as a result of other developments within sport, have been increasingly eager to seek the help of anyone who can improve the level of their performance. The conjuncture of these two processes, it is suggested, has been associated with two closely related developments. One of these developments — and one which is generally viewed as wholly legitimate — involves the emergence of sports medicine; the other — which is normally regarded as illegitimate — involves the increasing use by athletes of banned substances to improve their performance. The close association between these two developments has been clearly noted by Brown and Benner (1984: 32), who have pointed out that, as increased importance has been placed on winning, so athletes
have turned to mechanical (exercise, massage), nutritional (vitamins, minerals), psychological (discipline, transcendental meditation), and pharmacological (medicines, drugs) methods to increase their advantage over opponents in competition. A major emphasis has been placed on the nonmedical use of drugs, particularly anabolic steroids, central nervous system stimulants, depressants and analgesics.

In other words, the very processes which have been associated with the development of sports medicine have also been associated with a rapid growth in the illicit use of drugs. The relation between illicit drug use and processes of medicalization has also been noted by Donahoe and Johnson (1988: 126–7):

we live in a drug-oriented society. Drugs are used to soothe pain, relieve anxiety, help us to sleep, keep us awake, lose or gain weight. For many problems, people rely on drugs rather than seeking alternative coping strategies. It is not surprising that athletes should adopt similar attitudes.

It should be noted, that since our analysis stresses the conjuncture of these two processes, one within the world of medicine and the other within the world of sport, it follows that the increasing use of drugs in sport cannot be explained simply by reference to the changing patterns of behaviour amongst athletes. Indeed, we would suggest that the increasing use of drugs has been associated with the emergence, in both the world of sport and the world of medicine, of those who may be described as innovators or entrepreneurs. Referring first to the world of sport, it is hardly surprising that, given the increased emphasis which has come to be placed on winning, some athletes — and almost certainly a growing number — have been prepared to innovate by making illicit use of the fruits of medical and pharmacological research, or by themselves acting as ‘brokers’ who provide these fruits for others. Equally, however, it is a clear implication of the above analysis that there are doctors — and again the probability is that their number is growing — who may be regarded as medical ‘entrepreneurs’ in the sense that they are prepared to stretch the boundaries of ‘sports medicine’ to include the prescribing of drugs with the specific intention of improving athletic performance.

This point is of some importance for it suggests that the increasing use of drugs in sport has been associated with the development of a network of co-operative relationships between innovators or entrepreneurs from the two increasingly closely related fields of sport and medicine. In this respect,
our analysis is rather different from that of some other writers. Goodbody (The Times, 27 May 1987), for example, has argued:

Each generation of competitors uses the experience of its predecessors to find new illegal methods of improving performances. Each generation of administrators and doctors tries to stop every loophole, extend the number of banned drugs and become more sophisticated in its testing and trapping of offenders.

We would suggest that Goodbody’s argument is far too simplistic, primarily because it posits an unreal dichotomy or opposition between two groups – competitors and doctors – one of whom, it is suggested, seeks to use and the other to prevent the use of illicit drugs. As indicated above, we would argue in marked contradistinction to Goodbody, that all too frequently the illicit use of drugs is actually premised upon a significant degree of cooperation between ‘innovating’ athletes and ‘entrepreneurial’ doctors. There are, we believe, good grounds in support of this contention.

Donahoe and Johnson (1988: 62), in a phrase which is reminiscent of Goodbody’s argument, have suggested: ‘Athletes are enterprising people; as soon as detection methods are developed for one anabolic agent they move on to another.’ No doubt there are many athletes who are indeed enterprising people, though one might reasonably doubt whether many of them are sufficiently well-informed about recent developments in medicine and pharmacology to devise their own drug programmes – and more particularly, to avoid detection, as many undoubtedly do – without professional advice. In this context, it is worth noting that many drug regimens, such as those involving ‘stacking’, are very complex. ‘Stacking’ is a technique which is particularly used by weightlifters and involves the use of several different types of anabolic steroid concurrently. A typical ‘stacking’ programme has been described as follows (Donahoe and Johnson, 1988: 46):

The athlete may start a drugs programme by using a low dose of an oral anabolic steroid. The dose would be increased after a week or so and supplemented with a weekly injection of one of the long-acting steroids such as nandrolone decanoate. Over the next few weeks, the doses and frequency of these treatments would be increased. A month before competition, the athlete might be taking about ten times the therapeutic dose of oral steroids, plus about six or eight times the therapeutic dose of injectable long-acting steroids. In an attempt to avoid detection, for the few weeks prior to competition the synthetic drugs would be dropped, to be replaced by testosterone.
Without overstating the argument, it seems improbable that complex drug programmes of this kind have been worked out by the athletes themselves, without access to specialized advice, whilst it seems even more improbable that athletes have the specialized technical knowledge required to avoid detection, for this necessarily involves keeping one step ahead of what are becoming increasingly sophisticated testing procedures.

The case of so-called ‘blood-doping’ provides another instance of a form of cheating in which the critical technological breakthrough, as well as the administration of the treatment, clearly involves medical personnel. Blood-doping involves the removal of a few hundred millilitres of blood which is stored for a few weeks and then reinfused into the athlete, a process which boosts the oxygen-carrying capacity of the blood, and thus the quantity of oxygen available to the muscles. This process once again points to a significant degree of co-operation between competitors and doctors for, as Donahoe and Johnson (1988: 119) note, blood-doping ‘obviously requires the aid and skills of medical staff’.

In addition to the above considerations, there is also a good deal of direct evidence relating to the involvement of doctors in the use of drugs in sport. We now know, for example, that for several years prior to his disqualification at the Seoul Olympics, Ben Johnson had been taking anabolic steroids under the direction of his physician, Dr Mario Astaphan. Giving evidence under oath to a Canadian government inquiry, Astaphan (The Times, 26 May 1989) claimed that 32 athletes representing twelve countries and several sports had sought his help. Such examples of medical involvement in the use of drugs are not difficult to find. Dr Robert Kerr, a Los Angeles physician whose surgery is said to have become a ‘takeaway for Olympic athletes’, has claimed that in the Los Angeles area alone there are between 60 and 70 doctors who prescribe steroids for athletes (‘On the Line’, 1990). There is also evidence that at the Los Angeles Olympics of 1984 at least some team doctors were involved in blatantly exploiting a loophole in the doping regulations. Although beta-blockers were not at that time banned by the IOC, team doctors had to fill in declarations for all athletes using beta-blockers and state the doses used. If competitors produced a doctor’s certificate stating that they needed the drugs for health reasons, they would not be disqualified if drug checks proved positive. However, when urine specimens were screened there were several positives in the modern pentathlon contest. To the amazement of officials, team managers came forward with doctors’ certificates covering whole teams. In October 1984 Colonel Willy Grut, the secretary-general of the world body governing the modern pentathlon, challenged the IOC to reveal the names of those athletes who ‘clearly took dope, not for medical reasons, but to improve performance’
What is of importance in the context of the present argument is not the fact that these athletes took drugs but that the drugs appear to have been taken with the knowledge of team doctors who then protected the athletes against disciplinary action.

Such examples are not, of course, confined to the Olympic Games or to Olympic sports. One of the most celebrated cases in the US involved an eminent psychiatrist, Dr Arnold Mandell. Mandell was the founding chairperson of the Department of Psychiatry at San Diego, is a recognized expert on neurochemistry, is the recipient of millions of dollars in research grants and is the author of several books and hundreds of scientific papers. Mandell also worked with the San Diego Chargers in the National Football League. In 1974 he was dismissed after the NFL accused him of giving the team 1750 amphetamine pills over a three-month period. Mandell conceded that he wrote very large prescriptions and subsequently carried out research on amphetamine use by NFL players; in September 1978 at a national conference on amphetamine use he presented a paper called ‘The Sunday Syndrome’, in which he claimed that players typically took a high dose of amphetamines once a week during the game on Sunday (Donahoe and Johnson, 1988: 28–9).

Several other examples implicating doctors in the non-medical use of drugs could be cited from athletics, cycling and association football (Donahoe and Johnson, 1988: 161; The Times, 18 October 1982). These cases all come from Western Europe, but it seems probable that in Eastern Europe the medical profession is even more closely involved in the illicit use of drugs in sport than is the case in the West. There are, as we noted earlier, many allegations concerning the organized abuse of steroids, particularly in East Germany, some of them based on information from international athletes who have defected to the West. There is at least one advantage to what seems to be ‘official’ involvement in the use of drugs: it does mean that the athletes concerned do at least get regular and systematic medical monitoring. As Donahoe and Johnson (1988: 69) note: ‘While official involvement in doping is often attacked as state control by Western critics, and certainly cannot be condoned, there are probably many American or European athletes who would welcome the medical backup that accompanies tacit state approval of drug abuse.’

CONCLUSION

In this chapter we have suggested that if, as seems probable, sportsmen and -women have in recent years increasingly turned to the illicit use of drugs,
then this development can only be adequately understood by analyzing the changing network of relationships in which they are involved. In this regard, we have suggested that, as a result of changes within the structure of sport – changes associated particularly with structurally generated competitive pressures and with political and commercial developments – the pressure on sportsmen and -women to win, and the rewards of winning, have greatly increased. As a consequence, sportsmen and -women have increasingly been prepared to turn to a variety of specialists able to hold out the promise of helping competitors to improve the level of their performance. These developments within the structure of sport have coincided with another, largely autonomous development – the medicalization process – which has involved the extension of medical intervention into more and more areas of social life and which, particularly from the early 1960s, has increasingly involved doctors in the systematic use of medical and pharmacological developments in an effort to improve sporting performances. These developments have resulted in a coming together of two groups, sportspeople and doctors, one of whom has increasingly demanded, and the other of whom has increasingly been prepared to supply, specialist medical advice in the search for improved performances. The conjuncture of these developments in sport and in medicine has had two closely related consequences, one of which is normally seen as legitimate, the other as illegitimate. Thus it is suggested that the increasing competitiveness of sport and the medicalization process have been associated, on the one hand, with the rapid development of sports medicine, but that these very processes have also been associated, on the other hand, with the increasing use of prescribed drugs.

This analysis thus suggests that the increased use of drugs in sport in recent years is a process which is closely interrelated with a number of other major processes of social change on both the national and international levels. If this is indeed the case, it suggests that, for as long as those broader processes of change continue on their present lines of development, then the constraints on sportsmen and -women to use drugs illicitly may also continue to grow. If this proves to be the case, and if those sportspeople who use drugs are able to continue to rely on the network of co-operative relationships with those whom we have described as ‘entrepreneurial’ doctors, then the illicit use of drugs in sport may well prove extremely difficult to control.
Notes

1. It should be noted that since this chapter was written the IOC has added marijuana to the list of banned drugs, not because it affects sporting performance but on the grounds that it is apparently held to be 'damaging to youth and a threat to world peace'. This decision is not consistent with the earlier position taken by the IOC and it is difficult to see it as anything other than part of a 'moral panic' associated with an attempt to 'clean up' the image of athletics, particularly in the wake of the Ben Johnson affair. See The European, 8-10 June 1990.

2. We are aware of the fact that the idea of 'fairness' is one which, in practice, is imperfectly applied. The reality of the upper levels of sporting competition is that it often involves individuals or teams which are highly differentiated in terms of their access to resources and support systems.

References


The Development of Sports Medicine

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The Development of Sports Medicine

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The development of sports medicine can be understood in terms of a conjuncture involving processes of medicalization and the increasing competitiveness of modern sport. It is also suggested that the growing involvement of sports physicians in the search for championship-winning performances has led them not only to develop improved mechanical and psychological techniques, but also to play an active part in the development of performance-enhancing drugs and techniques. The argument is developed via three case studies: the relationship between sports medicine and drug use in some of the former communist countries of Eastern Europe; the early development of anabolic steroids in the United States; and the development of “blood doping.”

Le développement de la médecine sportive peut être compris en termes d’une conjoncture incluant les processus de médicalisation et de compétition croissante en sport moderne. Il est suggéré que l’implication grandissante des médecins sportifs dans la quête aux performances gagnantes les a amené non seulement à développer des techniques mécaniques et psychologiques améliorées, mais aussi à jouer un rôle actif dans le développement des drogues et techniques qui aident la performance. Cet argument est développé via trois études de cas: la relation entre la médecine sportive et l’usage des drogues dans certains des anciens pays communistes de l’Europe de l’est, le développement des stéroïdes anabolisants aux États-Unis et le développement du dopage par le sang.

The structure of sporting competition has been changing rapidly in the post-Second World War period, particularly since the late 1950s and early 1960s. Several important aspects of these changes—for example, the increasing professionalization and commercialization of sport and the changing relationship between sport and the media—have been extensively analyzed by sociologists. However, other, and arguably no less important, processes have received much less attention. One such process is the development of sports medicine. Given the undoubted significance of the development of sports medicine for modern sporting competition—one writer has suggested that “the entire enterprise of elite sport is best understood as a recent chapter in the history of applied medical research into human biological development” (Hoberman, 1992, p. 4)—it is perhaps surprising that the development of sports medicine has received scant attention from both sports sociologists and medical sociologists. The object of this paper is to help, in a modest way, to fill this gap by offering a preliminary sociological perspective on some of the processes involved in the development of sports medicine.

Quite clearly it is not possible within the confines of a journal article to offer a comprehensive analysis of all aspects of the development of sports medicine, and such an analy-
sis is certainly not attempted here. Rather, this paper focuses on two interrelated problems. The first part of this paper traces the development of sports medicine in the 20th century and suggests that many aspects of this development can be understood in terms of a conjuncture involving, on the one hand, processes of medicalization and, on the other, the increasing competitiveness of modern sport. In the second part of the paper, some aspects of the relationship between the development of sports medicine and the development and use of performance-enhancing drugs and techniques are explored.

Although some writers have suggested that the origins of sports medicine can be traced back to the Ancient Greeks and Romans (American Academy of Orthopaedic Surgeons, 1984; McIntosh, 1976; Percy, 1983; Ryan, 1989), the development of sports medicine in the form in which we know it today—the more or less systematic application of the principles of medicine and science to the study of sporting performance, and the institutionalization of this practice in the form of professional associations, research establishments, scientific conferences, and journals—is more properly seen as a development of the late-19th and 20th centuries. According to Ryan (1989, p. 3) the first use of the term sports medicine to describe an area of research and clinical practice centered around the performances of athletes, appears to have been in February, 1928, when two doctors attending the Second Winter Olympic Games at St. Moritz in Switzerland convened a meeting of physicians who were attending the Games with the teams of competing nations. It was at this meeting that the Association Internationale Médico-Sportive (AIMS) was founded. In 1934, the Association changed its name to the Fédération Internationale de Médecine Sportive (FIMS), the name it has retained ever since (Titel & Knuttgen, 1988, pp. 7-8).

Germany has perhaps a longer tradition of sports medicine than any other European country. The world’s first sports college, which included a sports medical curriculum, was founded in Berlin in 1920, and the world’s first sports medical journal was founded in 1924 by the German Association of Physicians for the Promotion of Physical Culture (Hoberman, 1992, p. 219). It is, therefore, not surprising that the first book to use the term sports medicine in its title was a German book: Dr. F. Herxheimer’s Grundriss der Sportsmedizin, published in 1933. The first book in English to use this title was J.G.P. Williams’ Sports Medicine, published in 1962 (Ryan, 1989, p. 4).

The development of sports medicine has been particularly rapid in the period since the early 1950s. Within Great Britain, a significant development was the establishment of the British Association of Sport and Medicine (BASM), which was founded in 1953 by Sir Adolphe Abrahams and Sir Arthur (later Lord) Porritt. The BASM now works closely with the National Sports Medicine Institute of the United Kingdom, which was formed in 1992 out of the former London Sports Medicine Institute. In the United States, the American College of Sports Medicine was established in 1954. In the same year, the American Medical Association appointed an ad hoc committee on injuries in sports that, in 1959, became a standing committee, the Committee on the Medical Aspects of Sports. Other significant developments within the United States included the establishment of a Committee on Sports Medicine by the American Academy of Orthopaedic Surgeons in 1962 and the founding of the American Orthopaedic Society for Sports Medicine in 1975 (Ryan, 1989, pp. 17-18). The American Academy of Paediatrics and the American Academy of Family Physicians have also established committees on sports medicine.

During the last 30 years or so, most countries have established national organizations concerned with sports medicine, and very many of these have affiliated to FIMS, which in
1989 had 83 member states (Hollmann, 1989, p. 5). FIMS has also encouraged the formation of sports medicine groupings based on regional and linguistic criteria; these currently include the Confederación Panamericana de Medicina del Deporte, the Northwest European Chapter of Sports Medicine, le Groupement Latin de Médicine du Sport, l’Union Balkanique de FIMS, the Asian Confederation of Sports Medicine, the Arab Federation of Sports Medicine, l’Union Africaine de Médicine du Sport, and la Société Méditerranéenne de Médicine du Sport (Tittel & Knuttgen, 1988, p. 11). Further evidence of the growing significance of sports medicine as an area of practice is provided by the fact that in 1981 the World Medical Association drafted a code of practice for doctors involved in sport (McLatchie, 1986, pp. 22-24).

As indicated above, the development of sports medicine has been particularly rapid in the period since the early 1950s. Sports medicine is now a recognized part of modern medicine, and the sports medicine practitioner is a well-established part of the sporting scene. Yet, so far, there has been no proper systematic sociological examination of this development. Sociologists have paid some attention to one specific area within sports medicine, namely the illicit use by athletes of performance-enhancing drugs (Bryson, 1990; Coakley, 1994; Lüschen, n.d.; Waddington & Murphy, 1992), but the development of sports medicine per se has been largely ignored. How then can we move toward a sociological understanding of what has been a significant development both within the world of medicine and within the world of sport?

In order to understand the development of sports medicine it is necessary to examine not only the changing structure of sport and sporting competition, but also to locate these changes within the context of changes in the structure of the wider society and, more particularly, within the context of changes in the structure of modern medical practice. In this regard, the process of medicalization has been of particular significance.

The Medicalization of Life

In an influential essay published in 1972, Irving Zola argued that in modern industrial societies medicine was becoming a major institution of social control. This process, he argued, was a largely insidious and often undramatic one that was associated with the "medicalizing" of much of daily living, a process that involves "making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence" (Zola, 1972, p. 487). The medicalization process has involved an expansion of the number and range of human conditions that are held to constitute "medical problems," a label that, once attached, is sufficient to justify medical intervention. Zola cites four such problems: aging, drug addiction, alcoholism, and pregnancy, the first and last of which were once regarded as normal processes and the middle two as human foibles and weaknesses. This has now changed, and medical specialties have emerged to deal with these conditions, one consequence of which has been to expand very considerably the number of people deemed to be in need of medical services. A similar process has occurred as a result of the development of "comprehensive" and psychosomatic medicine, both of which have considerably expanded the area of that which is held to be relevant to the understanding, treatment, and prevention of disease. The development of preventative medicine, in particular, has justified increasing medical intervention in an attempt to change people’s lifestyles, whether in the areas of diet, sleep, work, marital relationships, exercise, tobacco and alcohol consumption, or in the areas of safer driving or the fluoridation of water supplies.

The theme of the medicalization of life has subsequently been taken up by a number of other writers. Waitzkin and Waterman, for example, have offered an analysis of this
process in terms of what they called "medical imperialism" (1974, pp. 86-89). Perhaps the most famous thesis of this kind, however, is that associated with Ivan Illich. Illich argues that the medicalization of life involves a number of interrelated processes, including growing dependence on professionally provided care, growing dependence on drugs, medicalization of prevention, and medicalization of the expectations of lay people. One of the consequences has been the creation of "patient majorities," for, Illich argues (1975, p. 36), people "who are free of therapy-oriented labels have become the exception." Large numbers of people are now regarded as requiring routine medical attention, not because they have any definable pathology, but "for the simple fact that they are unborn, new-born, infants, in their climacteric, or old" (Illich, 1975, p. 44). In other words, the expansion of what falls within the province of medicine has now reached the point at which, as de Swaan (1988, p. 243) put it, "there remain only patients and those not yet patients."

It is an important part of the argument in this paper that, particularly in the last 3 decades or so, the medicalization process has encompassed sport. Central to this process has been the rapid development, particularly since the 1950s, of sports medicine, an area of practice described by two prominent British exponents (J.G.P. Williams & Sperryn, 1976, p. ix) as an integrated multidisciplinary field embracing the relevant areas of clinical medicine (sports traumatology, the medicine of sport and sports psychiatry) and the appropriate allied scientific disciplines (including physiology, psychology and biomechanics).

Some of the processes involved in the medicalization of sport—and in particular the development of an ideology justifying increasing medical intervention—can be illustrated by reference to textbooks in the area of sports medicine. This ideology is, for example, clearly expressed in one of the early British texts in the field: J.G.P. Williams' *Sports Medicine*, published in 1962, was, as noted earlier, the first English language text to use the term *sports medicine* in its title. Perhaps because it was one of the earliest British texts, Williams may have felt obliged to try to establish the legitimacy of sports medicine; some of the introductory comments in the book may perhaps be regarded as a manifesto on behalf of the sports medicine practitioner. Thus Williams argues that the intensity and diversity of modern competitive sport have "resulted in the emergence from the general mass of the population of a new type of person—the trained athlete"; he goes on to argue—some may feel not very convincingly—that the trained athlete "is as different physiologically and psychologically from the 'man in the street' as is a chronic invalid." This argument is, however, important in establishing a justification for medical intervention, for he goes on to suggest, "Just as extreme youth and senility produce peculiar medical problems, so too does extreme physical fitness" (J.G.P. Williams, 1962, p. vii).

One can see here the development of the idea, now very widespread, that athletes require routine medical supervision, not because they necessarily have any clearly defined pathology but, in this case, simply because they are athletes. This position is, in fact, spelled out quite unambiguously in the foreword to Williams' book by Sir Arthur Porritt, who was at the time the President of the Royal College of Surgeons of England and the Chairman of the British Association of Sport and Medicine. Porritt's (in J.G.P. Williams, 1962, p. v) position could hardly have constituted a clearer statement of what is involved in the medicalization process, for he argues quite baldly that "those who take part in sport and play games are essentially patients." Athletes have thus become yet one more group to add to Illich's list of those—the unborn, new-born, infants, and so on—who are held by defini-
tion to require routine medical supervision, irrespective of the presence or absence of any specific pathology.

One consequence of the development in recent years of sports medicine (and of closely associated disciplines such as exercise physiology, biomechanics, and sports psychology), has been to make traditional methods of training for sporting events increasingly outmoded. At least at the higher levels of sport, both amateur and professional, the image of the dedicated athlete training alone or with one or two chosen friends no longer corresponds to reality. Instead, the modern successful athlete is likely to be surrounded by—or at least to have access to—and to be increasingly dependent upon, a whole group of specialist advisers, including specialists in sports medicine. Moreover, this dependence on the practitioner of sports medicine goes far beyond the treatment of sports injuries; as J.G.P. Williams and Sperryn (1976, p. 1) point out, as

practice for the competitive event takes place . . . the sportsman [sic] seeks systematic methods of preparation. He examines such technical and scientific information as is available about the way his body performs its athletic function and turns to the doctor as physiologist.

One consequence of these developments has been to make top-class athletes more and more dependent on increasingly sophisticated systems of medical support in their efforts to run faster, jump farther, or compete more effectively in their chosen sport. As the former Amateur Athletics Association national coach, the late Ron Pickering noted in his foreword to Sperryn's *Sport and Medicine* (1983, p. vi), few would deny that "nowadays medical support is essential for the realization of the athlete's natural capacity for optimum performance"; indeed, at the highest levels of competition the quality of the medical support may make the difference between winning and losing. Just how sophisticated modern systems of medical back-up have become is illustrated by Pickering's tongue-in-cheek comparison between the limited amount of scientific knowledge that was available to coaches at the start of his career and the vast amount of knowledge that has subsequently been gained from experiments on athletes "who have given blood, sweat, urine, muscle biopsies and personality inventories, have often been immersed in tanks, and photographed naked in three dimensions at altitude."

It would, however, be quite wrong to suggest that athletes are simply unwilling "victims" of medical imperialism, for, as de Swaan (1988, p. 246) has noted, professionals—in this instance doctors—"do not simply force themselves upon innocent and unknowing clients." In the case of sport, a number of developments, particularly in the post-Second World War period, have led sports men and women to increasingly turn for help to anyone who can hold out the promise of improving their level of performance. The most important of these developments are probably those that have been associated with the politicization of sport, particularly at the international level, and those that have been associated with massive increases in the rewards—particularly, but not exclusively, the material rewards—brought by sporting success. Both these processes, it can be suggested, have had the consequence of increasing the competitiveness of sport; one aspect of this increasing competitiveness has been the downgrading, in relative terms, of the traditional value associated with taking part while greatly increasing the value attached to winning.

It should be noted that although the trend toward the increasing competitiveness of sport has been particularly marked in the post-1945 period, the trend is a much longer term trend and is a good example of what Elias (1987, pp. 99-100) called a "blind" or "unplanned" long-term social process. As Dunning (1986) has pointed out, this process can be
traced back over 2 or more centuries in Britain and has been associated with the processes of industrialization and sthte development. Within the context of the present paper, however, the discussion is confined to a brief examination of some relatively recent, post-1945, developments.

The Politicization of Sport

Although the relationship between politics and sport is by no means exclusively a post-World War Two phenomenon—witness the Berlin Olympics of 1936—there can be little doubt that sport has become increasingly politicized since 1945. To some extent, this process has been associated with the development of independent nation-states in Black Africa and elsewhere. Several outstanding athletes have emerged in many of those states, and their international successes have been a major source of pride in new nations; the governments of these nations have often sought to use these sporting successes to help establish a national identity and a sense of national unity.

Of rather greater importance, however, was the emergence in the 1940s and 1950s of state socialist or communist societies in many parts of Eastern Europe and in China and, associated with this, the emergence of the Cold War and of superpower rivalry. Within this context, sporting competition took on a significance going far beyond the bounds of sport itself, for sport—at least within the context of East-West relations—became to some extent an extension of the political, military, and economic competition that characterized relationships between the superpowers and their associated blocs. Thus, comparisons of the number of Olympic medals won by the United States and the Soviet Union or the medals won by the two Germanies took on a new significance, for the winning of medals came to be seen as a symbol not only of national pride but also of the superiority of one political system over another. As many governments came to see international sporting success as an important propaganda weapon in the East-West struggle, so those athletes who emerged as winners came increasingly to be treated as national heroes with rewards—sometimes provided by national governments—to match.

Sport and Commercialization

If the politicization of sport has been associated with an increase in the competitiveness of international sport, this latter development has also been facilitated by the growing commercialization of sport in the West. Although the winning of an Olympic medal has doubtless been considered a great honor ever since the modern Olympics were founded in 1896, it is undoubtedly the case that in recent years the nonhonorific rewards—and in particular the financial rewards—associated with Olympic success have increased massively. For example, successful athletes are not only in a position to demand substantial appearance fees for competing in major meetings, but, much more importantly, they can also earn huge incomes from television commercials, sponsorship, and product endorsement. Although this development appears to be a fairly general one within Western societies, the financial rewards associated with Olympic success are probably greatest in the United States. Dr. Robert Voy (Stubbs, 1990), who was the chief physician to the U.S. team at the 1988 Seoul Olympics, estimated that in the US at that time the average Olympic gold medal was worth around $1 million in sponsorship, television advertisements, and product promotion. He went on to point out, however, that such fabulous rewards are available only to those who come first for, as he put it, "second place doesn't count."
As the rewards to be gained from sporting success have increased, so has the emphasis placed on winning. This process has, according to the leading U.S. athletics coach, Brooks Johnson (Stubbs, 1990), resulted in a situation in which many top-class international athletes “wake up with the desire and the need and the compulsion and the obsession to win and they go to sleep with it. . . . Make no mistake about it, an Olympic champion is clinically sick.”

The Sport/Medicine Axis

At this stage, it may be useful to summarize briefly the argument thus far. I have suggested that the development of sports medicine has been associated with two major processes of social change, one within the world of medicine and the other within the world of sport. The first of these processes is what has been called the medicalization of life or medical imperialism, whereas the second process has involved the increasing competitiveness of modern sport and the growing emphasis that has come to be placed on the importance of winning. More specifically, I have suggested that certain developments within the structure of medical practice have meant that medical practitioners have been increasingly prepared to make their professional knowledge and skills available to athletes at the very time when athletes, as a result of developments within sport, have been increasingly eager to seek help from anyone who can hold out the prospect of improving their level of performance. The conjunction of these two relatively autonomous processes has been central to the development of sports medicine.

Although both the medicalization process and the increasing competitiveness of sport can be traced back well beyond the Second World War, both processes have been particularly rapid in the period since 1945. The convergence of these two processes in the post-1945 period has had a major impact on the development of sports medicine in two particular respects. First, as we saw earlier, it has resulted in the rapid expansion of what was, before 1945, a relatively small and marginal area within both sport and medicine. However, the growing involvement of medical practitioners in a sporting world that has become much more competitive and success-oriented in the post-1945 period has had a second, and perhaps less obvious, impact on the development of sports medicine. This involvement has been associated not only with a rapid expansion of the area, but also with an important change in the orientation of practitioners of sports medicine, particularly on the part of senior practitioners involved in research who have had the ability largely to define the agenda of— and therefore the major lines of development of— sports medicine. This development has been associated with a radical change in the nature of sports medicine in the post-1945 period. In order to understand this point more fully, it is necessary to retrace our steps and reexamine in more detail some of the key aspects of the development of sports medicine.

The Early Development of Sports Medicine

The development of modern sports medicine can be traced back to the very end of the 19th century and the first decades of the 20th century. However, in tracing the development of sports medicine back to this period, there is a danger of overemphasizing the continuities and of failing to recognize the discontinuities in this developmental process. In this regard, it is important to note that the difference between contemporary sports medicine and the sports medicine of the turn of the century lies not simply in the greater quantity of information now available, important though this undoubtedly is, but also in the fact that, in
the earlier period, the orientations of the researchers and the problems they sought to resolve were also rather different from what they are now. This aspect of the changing structure of sports medicine has, perhaps, been brought out most clearly by Hoberman; my argument in this section of the paper draws upon Hoberman's work, though not in a wholly uncritical way.

In describing the work of the early pioneers of sports medicine in the late-19th and early-20th centuries, Hoberman pointed out that the investigation of human athletic potential was not a primary goal of those who studied the human organism at that time. In those days, the high-performance athlete was "still a curiosity and not a charismatic figure at the centre of huge commercial enterprises like the Olympic Games" (Hoberman, 1992, p. 6). Sport was considered as just one among a number of activities of interest to the physiologist; as a source of interesting physiological data, sport occupied a relatively humble position within a much broader range of physical performances such as manual labor and military service. In commenting on this early period in the development of sports medicine, Hoberman (1992, p. 6) pointed out that the "scientific marginality of sport during this period, and the general lack of interest in boosting (as opposed to investigating) athletic performance, has a quaintly premodern quality."

It is important to emphasize the general absence among the pioneers of sports medicine of any interest in boosting athletic performance, for this is one of the most important characteristics distinguishing the sports medicine of the late-19th and early-20th centuries from the sports medicine of today. In relation to the former, Hoberman (1992, p. 8) has pointed out that

the scientists who turned their attention to athletic physiology during the late nineteenth and early twentieth centuries did so not to produce athletic wonders but to measure and otherwise explore the biological wonders presented by the high-performance athlete of this era. It was a time, one scientist of the age wrote, when phenomena once considered mere curiosities or freaks of nature called out for scientific investigation.

Those involved in the experimental approach to athletics showed little interest in boosting performance. The Austrian physiologist Oscar Zdth, for example, studied the pedaling action of cyclists as a problem in muscle physiology without referring to the possibility of improving performance. Similarly, in 1903, an American physiologist offered a scientific rationale for the "warming-up" procedure for sprinters, but said nothing about faster sprinting. To cite Hoberman again (1992, p. 10),

In short, the primary interest of these scientists was to discover the natural laws that regulated the functioning of the body. If they did not express an interest in applying science to the boosting of athletic performance it was in part because the scientific mysteries they found in the world of high-performance sport were already exciting enough.

Not only is it the case that these scientists had little interest in boosting athletic performance, but it is also the case that some of the leading sports physicians of the period expressed concern about what they saw as the physiological dangers of sporting overexertion—for men as well as for women—and, for this reason, actively opposed the search for new records in athletics. Particularly interesting was the career of Philippe Tissié. Born in 1852, Tissié was a contemporary and fellow countryman of Pierre de Coubertin, and probably the most important sports physician of the fin-de-siècle. Although Tissié made some pioneering medical observations on a record-breaking long distance cyclist, he was by no
means an advocate of such record-breaking attempts; indeed, one of the characteristics that sets this early pioneer of sports medicine apart from his modern counterparts is the fact that Tissié actually disapproved of the high-performance sport of his era. Tissié did not share de Coubertin's view that breaking records was a central part of the athlete's task, and indeed, Tissié strongly opposed, because of what he saw as their medical dangers, the competitive sports that de Coubertin promoted. The conflict between the two came to a head in 1894 when, at the conference of the French Association for the Advancement of Science, Tissié successfully opposed de Coubertin's appeal for track-and-field events (Hoberman, 1992, pp. 80-84).

The orientation that characterized the work of the early exponents of sports medicine—and in particular the emphasis on scientific puzzle solving rather than on boosting athletic performance—can also be seen in the work of some leading sports physicians in the early interwar period. A prominent example is provided by the work of A.V. Hill, the British physiologist and Nobel Prize winner who was based at Cornell University and who analyzed athletic performance as part of a larger scale scientific problem. In commenting on Hill's work, Hoberman (1992, p. 11) pointed out that

In the last analysis . . . and despite all its physiological sophistication, Hill's approach to athletic performance was not so different from the turn-of-the-century idea that the high-performance athlete was a wonder of nature—a marvellous phenomenon that did not require improvement.

In summarizing the characteristics of sports medicine at the turn of the century, Hoberman suggested that

By the standards of our technological and sports-obsessed age, the last decades of the nineteenth and the early decades of the twentieth centuries were a premodern world in terms of physiological investigations of human performance. Dynamic athleticism was a peripheral preoccupation rather than the self-evident ideal it has become for many people in widely varying cultures across the globe. What we call "sportive" aptitudes and efforts were viewed in the context of a plethora of human frailties and performances, all of which could be studied to yield clues about the nature of the human mind and body. (Hoberman, 1992, p. 63).

The early sports physicians, Hoberman suggests, saw "sportive performances serving physiology as experimental data, rather than the other way round," with the emphasis being placed on the "discovery of physiological laws rather than the application of these discoveries to athletic achievement." In more recent years, however, the increased emphasis that has come to be placed on winning and on breaking records has dramatically changed the relationship between athletic performance and sports medicine. If, in the early years of this century, "sport served the ends of science rather than the other way round," it is now the case that, in contrast to that earlier period, "the modern outlook sees symbolic importance in the pursuit of the record performance, thereby putting physiology in the service of sport" (Hoberman, 1992, pp. ix, 78).

It may be argued that, in setting up a dichotomous conceptualization of the relationship between athletic performance and sports medicine—that is, either sport serves medical science, or medical science serves sport—Hoberman overstates his case. It might be suggested, for example, that the present relationship between sport and medicine is one from which both medical scientists and sportspeople derive what they consider to be benefits, the former in terms of increased knowledge of human physiology and the latter in terms of improved athletic performances. Nevertheless, Hoberman properly draws attention to a pro-
cess that, beginning sometime in the interwar period and accelerating rapidly in the last 3 or 4 decades, has involved a dramatic shift in the research orientation of many leading sports physicians and an equally dramatic change in the nature of sports medicine as a discipline. This process has involved a radical shift away from the situation in which sports physicians, in the first few decades of this century, saw sport primarily as a source of data for the study of human physiology and were more or less uninterested in, and in some cases even hostile to, the attempt to set new athletic records; conversely, as sports physicians have become more and more involved in a sporting world that, particularly in the post-1945 period, has become increasingly competitive, so have their scientific activities both increasingly underpinned and increasingly been given meaning by, the search for winning, and perhaps above all, for record-breaking athletic performances. The late-19th- and early-20th-century pioneers of sports medicine were largely unconcerned about improving athletic performance; however, this has now become an important part of the raison d'être of contemporary sports medicine.

These changes within the structure of sports medicine should not be seen as unproblematic, for an examination of the development and contemporary structure of sports medicine—and in particular, an examination of the growing involvement of practitioners of sports medicine in the search for improved athletic performance—suggests that there are some aspects of the practice of modern sports medicine that raise a number of problems, not just on a sociological level, but also in terms of medical and ethical considerations. One such area concerns the relationship between the development of sports medicine and the development and use of performance-enhancing drugs. Within the context of this paper, my concern is with the sociological issues raised in this connection; I am happy to leave discussion of the medical and ethical issues to others.

**Sports Medicine and the Development of Performance-Enhancing Drugs**

A more or less standard feature of all modern textbooks on sports medicine is the inclusion of a chapter on the use of performance-enhancing drugs. Such chapters usually include basic information on the performance-enhancing effects of different drugs, on the side-effects and other medical complications associated with their use, and advice to physicians on how to recognize the illicit use of drugs by athletes under their care. Associated with the inclusion of information of this kind in textbooks of sports medicine is the public perception of the practitioner of sports medicine as an expert who plays a vital role in the fight against what is commonly regarded as the abuse of drugs in sport. However, an analysis of the relationship between the development of sports medicine and the development and use of performance-enhancing drugs suggests that this relationship is rather more complex than appears to be the case at first sight, and certainly a good deal more complex than is usually presented in textbooks of sports medicine.

In particular, such an analysis suggests that the growing involvement of practitioners of sports medicine in high-performance sport, especially since the 1950s, has increasingly involved them in the search for championship-winning or record-breaking performances. This has led them in the direction of not only developing improved diet or mechanical and psychological techniques, but also—though it is not suggested that they have always been aware of the longer term consequences of their actions—to play an active part in the development and use of performance-enhancing drugs. Thus it is suggested that, far from being one of the key bastions in the fight against the use of performance-enhancing drugs in sport,
Sports medicine has actually been one of the major contexts within which performance-enhancing drugs have been developed and used. In this sense, it may be said that the development of performance-enhancing drugs and techniques is not something that is alien to, but something that has been an integral part of, the recent history of sports medicine. This aspect of the development of sports medicine is worth examining in rather more detail, and will be explored via an examination of three illustrative case studies: the relationship between sports medicine and the use of drugs in some of the former communist countries of Eastern Europe; the early development and use of anabolic steroids in the United States; and the development of the technique that has come to be known as "blood doping."

Sports Medicine and Drug Use in Eastern Europe

For many years prior to the collapse of the communist regimes in Eastern Europe, there were widespread suspicions among Western observers that the outstanding successes of many East European, particularly East German and Soviet, athletes were associated, at least in part, with the use of performance-enhancing drugs. Since the collapse of those regimes, much more information has become available, and we now know that performance-enhancing drugs were used systematically by those involved in the sports medical establishments of some Soviet bloc countries in their attempt to produce Olympic medal-winning athletes.

It is important to recognize that there were important differences between the former communist countries of Eastern Europe, and it would be wrong to assume that in all of these countries the use of drugs to boost athletic performance was a common phenomenon. In this context, it should be noted that although states such as the former East Germany and the Soviet Union systematically used sport as a means of seeking international recognition and prestige, other communist countries, of which Albania was perhaps the most striking example, were characterized by a relative lack of involvement in international sporting competition; there is no evidence to suggest, nor any reason to suppose, that athletes in countries such as Albania were involved in the systematic use of performance-enhancing drugs.

It would also be very misleading to suggest that the successes of East German and Soviet athletes can be explained simply in terms of the use of performance-enhancing drugs, for in both countries there was a well developed system for talent-screening; all aspects of the training and development of elite athletes were carefully monitored by sports physicians who worked within a highly sophisticated system of sports medicine. Nevertheless, it is clear that the systematic use of drugs was an integral part of the East German and Soviet systems. The leading Western expert on sport in the former Soviet Union is probably James Riordan, who has pointed out that

It should come as no surprise that, given the "win at all costs" mentality that came to dominate the sports administrations in some East European countries, there had been long-term state production, testing, monitoring and administering of performance-enhancing drugs in regard to athletes as young as 7–8. (Riordan, 1994)

Elsewhere, Riordan (1991, p. 122) has suggested that practices such as this have cast "a shadow over the role of sports medicine, or at least that part of it that has worked on producing ever faster, stronger, more skilful athletes—at any cost."

There is, perhaps, no need to document in detail the multiplicity of ways in which, we now know, members of the sports medicine establishments in the Soviet Union and East Germany were involved in the use of performance-enhancing drugs. What is important to
note is that the use of such drugs was a systematic part of Soviet and East German sports policy, and that it involved a wide variety of people, including the "coach-pharmacologist," sports physicians, and government ministers. In East Germany, for example, the administration of performance-enhancing drugs to athletes involved personnel in a number of organizations, including the German College of Physical Culture (DHIK), the Research Institute for Physical Culture and Sport (FKS), the Central Institute for Microbiology and Experimental Therapy (ZiMET), the pharmaceutical company VEB Jenapharm, the Central Institute for Sports Medical Services, the Central Doping-Control Laboratory in Kreischa, the Institute for Aviation Medicine, and the Health Ministry in East Berlin. According to Hoberman (1992, p. 222), a "Sports Medical Commission passed doping instructions down the line to sports physicians and trainers who would distribute the drugs and often extract a vow of silence from athletes."

Similarly, it was revealed in 1989 that 7 years previously, two deputy sports ministers in the Soviet government had signed a document prescribing anabolic steroids as part of the preparation for Soviet cross-country skiers, setting out a program to test the effects of steroids and for research into ways of avoiding detection (Riordan, 1991, pp. 122-123). As Riordan noted,

"Drug taking was organized at the top and involved parts of the sports medical establishment; no athlete was allowed overseas unless he or she had a clearance test at a sports medicine dispensary before departing. At the Olympics of Montreal (1976) and Seoul (1988), it has now been revealed, the Soviet team had a hospitality ship used as a medical centre to ensure that Soviet competitors were "clean" at the last moment. (Riordan, 1991, p. 123)"

It is important to emphasize that the use of drugs by Soviet and East German athletes was not something done against the advice of, or without the knowledge and consent of, those involved in the sports federations and in the sports medicine establishments of those countries; rather it is the case that the drugs were provided by the state, and that all aspects of the athletes' development, including those relating to the administration of drugs, were supervised and monitored by specialists in sports medicine. Within the context of sport in some of the former communist regimes of Eastern Europe, therefore, it is not possible to separate out the development and use of performance-enhancing drugs from the development of sports medicine, for one was an integral part of the other. The use of performance-enhancing drugs was viewed simply as one part of the scientific armory that also included such things as diet, exercise physiology, and biomechanics, and that was available to sports physicians in their efforts to produce medal-winning athletes.

**The Development and Use of Anabolic Steroids in the United States**

In the early 1950s there were persistent rumors to the effect that sports scientists in the Soviet Union had been experimenting with the use of testosterone in an attempt to boost the performances of Soviet athletes. The validity of these rumors was confirmed by evidence obtained by Dr. John Ziegler, who was the team physician to the United States team at the 1954 World Weightlifting Championships in Vienna. On returning to the United States, Ziegler obtained some testosterone and tested it on himself, on the U.S. weightlifting coach Bob Hoffman, and on several East Coast weightlifters. Ziegler was impressed by the anabolic, or muscle-building, effects of testosterone but was concerned about some of the side effects. According to Dr. Robert Voy,
In an attempt to help Western athletes compete more effectively against the Soviets who used testosterone, and in an effort to reduce the bad side effects of testosterone—namely, acne, hair loss, prostate enlargement, and shrinkage of the testicles—Dr. Ziegler aided the CIBA Pharmaceutical Company in the development of Dianabol, or, in generic terms, methandienone. (Voy, 1991, p. 9)

As developed by CIBA, the drug was not intended for use by athletes, but was developed for use in treating patients suffering from burns and certain postoperative patients. However, as Todd (1987, p. 94) has noted, Dr. Ziegler "had another agenda, and what he did with Dianabol was critical in the spread of anabolic drugs in sport." With the cooperation of the national weightlifting coach, Ziegler persuaded three weightlifters to begin using Dianabol. Almost immediately, the three lifters began making very rapid gains in strength and muscle size, and as the lifters began to approach the world record level, other lifters clamored for information about how this rapid improvement had been achieved. It soon became widely known that the success of the three lifters, by this time all national champions, had been associated with their use of Dianabol. Voy (1991, p. 10) has noted that "With the introduction of Dianabol in the late 1950s, anabolic-androgenic steroids really got their initial use," and he adds that they "became popular very quickly"; indeed, anabolic steroids were adopted so quickly by American athletes that, by 1968, Dr. Tom Waddell, who came sixth in the decathlon in the Mexico Olympics of that year, estimated that a full third of the U.S. track-and-field team had used steroids at the pre-Olympic training camp held at Lake Tahoe (Todd, 1987, p. 95).

As both Voy and Todd recognize, Ziegler played a central role in helping to produce "a climate of rising expectations in which strength athletes began a big arms race, fueled by an ever expanding array of pharmaceuticals" (Todd, 1987, p. 94). In the mid-1980s, the central role of Ziegler in the development and use of anabolic steroids was recognized, with wonderful irony, in the name of a California-based business that supplied athletes with steroids by mail-order; the business was called the John Ziegler Fan Club (Todd, 1987, p. 104).

As noted earlier, it is not suggested that sports physicians who have become involved in the search for performance-enhancing drugs have been fully aware of the longer term consequences of their actions, for their actions, like all human actions, are constrained by a complex network of relationships of which they are likely to have, at best, only a limited awareness. In the case of Dr. Ziegler, Voy (1991, p. 10) has pointed out that, particularly when he became aware of the high doses being taken by some athletes, Ziegler realized the mistake he had made by helping to introduce these drugs to the athletic community. It was almost a sports world analogy to the story of Dr. Frankenstein. Soon after Dianabol hit the market, Dr. Ziegler knew he had created a monster, a fact he regretted for the rest of his life.

It is important to emphasize that it is not possible to dismiss Ziegler simply as a charlatan, as a disreputable practitioner on the fringes of, or even outside of, orthodox sports medicine. Nor is it possible to dismiss Ziegler as a cheat whose actions ran counter to the rules of fair play; in this context it is important to note that, as Voy points out, in the 1950s and 1960s, taking pills to enhance performance was not considered unethical and was not against the rules of any sporting competition, for there were no antidoping regulations at that time. This was a period, it should be recalled, when more effective drugs—most notably antibiotics—were becoming available to doctors in their treatment of patients, and when patients were also becoming more aware of the therapeutic possibilities offered by new...
drugs. America was, as Voy puts it, "a society that was just developing the pill-popping scene" and within this context, it is not surprising that both sports physicians and athletes should have looked to the pharmaceutical industry to improve athletic performances, just as it held out the possibility of improving many other aspects of people's lives. In this sense, Ziegler's actions should be seen not as those of an idiosyncratic zealot, nor as the actions of a disreputable cheat, but simply as the actions of a sports physician whose involvement in the increasingly competitive world of modern sport led him, just as it led other sports physicians, toward the search for performance-enhancing drugs, a development that at the time was seen as legitimate but which later came to be regarded as a form of cheating.

Of course, it might be objected that both case studies cited so far are atypical and that, as a consequence, they cannot be regarded as shedding much light on the relationship between the development of sports medicine and the search for, and the use of, performance-enhancing drugs. Thus it might be argued that the examples of sports medicine in Eastern Europe that related to totalitarian communist regimes (which no longer exist) were "abnormal" and can therefore shed little light on the development of sports medicine in the liberal democracies of the West. In similar fashion, it might be objected that the case study of the development of Dianabol, though relating to a liberal democracy, also relates to a period when there were no rules prohibiting the use of performance-enhancing drugs. The situation then was therefore very different from the one that exists today, in which there are relatively clear rules prohibiting the use of such drugs; on this basis, it might be objected that the situation described in relation to the development of Dianabol was merely an "unfortunate," one-off incident and not one that would be likely to be repeated today. In the context of possible objections of this kind, the third case study—the development of the technique known as blood doping—is particularly revealing.

**Blood Doping**

Blood doping does not involve the administration of drugs, but is a technique involving the removal from an athlete of some blood that is stored and later reinfused into the athlete. The removal of this blood stimulates the bone marrow to form more red cells, and the athlete's blood returns to normal after 10–12 weeks. The stored blood is then reinfused into the athlete a couple of days before competition; the extra red cells boost the oxygen-carrying capacity of the blood, and thus the quantity of oxygen available to the muscles.

Although some early work on blood doping had been done in the 1940s, the technique did not become associated with sport until many years later. The first systematic research studies examining the effects of blood doping on endurance and performance were conducted in Sweden during the late 1960s and early 1970s by Professor Bjorn Ekblom and his colleagues at the Institute of Physiology of Performance in Stockholm. They initially reported significant increases in maximum oxygen uptake and went on to claim that blood doping was associated with significant improvements in performance (Donohoe & Johnson, 1986, pp. 116-117).

In the 1970s and early 1980s many similar studies were undertaken by sports physicians and related specialists within sports medicine with a view to discovering whether blood doping was indeed an effective means of improving performance. Although there were some contradictory findings from the early studies, by the early 1980s a consensus of opinion was emerging to the effect that, carried out in the appropriate way, blood doping was indeed an effective way of increasing maximum oxygen uptake and endurance capacity (Gledhill, 1982;
A review of the contradictory findings from earlier studies also led to considerable refinements in the technique of blood doping. Thus, for example, it was suggested that the failure of some of the early studies to find a significant improvement in performance following reinfusion was associated with the use of inadequate reinfusion volumes, with premature reinfusion of blood following removal, or with inappropriate methods of storing the blood. Sports physicians were thus able to indicate that maximum impact in terms of improving athletic performance, a specified minimal amount of blood should be reinfused, there should be a specified minimal interval between removal of the blood and reinfusion, and that the blood should be stored by freezing rather than by refrigeration in order to avoid the loss of red cells in the blood (Gledhill, 1982).

Outside the world of sports medicine there had been some popular interest in blood doping in the 1970s when some commentators suggested that the Finnish runner Lasse Viren, a double gold medalist at both the 1972 and 1976 Olympics, had been blood doped; Viren vigorously denied the suggestion, saying that he drank only reindeer milk. Media and popular interest in the technique were revived when, following the spectacular success of the United States cycling team at the Los Angeles Olympics in 1984—the United States, which had not won an Olympic cycling medal since 1912, dominated the cycling events at the 1984 Games, winning a total of nine medals, including four gold—it was revealed that several members of the U.S. team had been blood doped (Cramer, 1985; Pavelka, 1985; Weaver, 1985). Following these revelations, the International Olympic Committee (IOC) declared the practice illegal and funded research into the development of methods for detecting blood doping (Collings, 1988).

In considering the development of the technique of blood doping since the early 1970s, it should be noted that research that demonstrated the effectiveness of blood doping as a method of boosting athletic performance and that also led to considerable refinements of that technique was carried out by sports physicians and related specialists within sports medicine. It is important to emphasize that those involved in this research were not those who might be regarded as “quacks,” working on the illegitimate fringes of sports medicine and rejected by their more reputable colleagues; they were in fact highly reputable sports physicians working within the mainstream of sports medicine, and their research was published, not in underground publications that circulated illicitly, but in the mainstream journals in sports medicine.

Viewed sociologically, what one might call the “moral career” of blood doping is very interesting for, within 2 decades, what had formerly been regarded as a legitimate research area for sports physicians seeking to improve athletic performance has now come to be regarded as a form of cheating that is banned under the antidoping rules of the IOC. A brief examination of the shift in the status of blood doping, from legitimate to illegitimate technique, is particularly revealing in terms of understanding the relationship between sports medicine and the use of performance-enhancing drugs and techniques.

An examination of the early literature on blood doping suggests that sports physicians initially regarded blood doping simply as one of many science-based techniques that held out the possibility of boosting athletic performance. Furthermore, they had little awareness of the possibility, at least in these early stages, that its use might be construed as a form of cheating. For example, in one of the major British textbooks, *Sports Medicine*, by J.O.P. Williams and P.N. Sperryn (1976), there is just one brief reference to blood doping, which is as follows:
Experimental re-transfusion of subjects with their own red cells after an interval of four weeks was thought to give improved performance, but this has subsequently been denied by further studies. In view of the dangers inherent in the whole process of blood transfusion, it is unlikely that further developments can be expected. (p. 158)

We need not concern ourselves here with the inaccuracy of their forecast about future developments; what is of interest is the absence of any suggestion that such a technique might be construed as cheating. This is confirmed by the fact that the discussion of blood doping is located, not in the chapter on doping, but in a chapter entitled “General Medical Aspects of Sport.” Within this chapter, the brief discussion of blood doping is located in a section on “Hazards of Exercise” that deals with such things as general medical screening, inoculations, routine clinical examinations, physiological testing, infections, sex, and skin disorders. One can only conclude that Williams and Sperryn considered it appropriate to discuss blood doping under the heading “General Medical Aspects of Sport” and that they saw no reason to include it in their discussion of doping. This would suggest that they regarded it as a legitimate area for research and development—even if, in their view, it was an unpromising development—for practitioners of sports medicine.

Seven years later, Sperryn’s Sport and Medicine (1983) included a slightly expanded discussion of blood doping, but there was still no suggestion that blood doping might be construed as a form of cheating. After a brief discussion of some of the technical aspects of blood doping, Sperryn concludes,

In summary, while this method is theoretically attractive, its practice must be extremely difficult to regulate safely and efficiently under all the stresses of athletic competition and, in view of all the provisos outlined, it is unlikely to become widespread. (1983, p. 27)

Again we are not concerned with whether or not Sperryn’s prediction about the use of blood doping was correct—this was the year before the United States cycling team used the technique to such good effect—but with the absence of any consideration that the use of the technique may be a form of cheating. In this context, Sperryn rejects the technique not because he considers its use runs counter to the spirit of “fair play,” but because of certain technical difficulties in using it “under all the stresses of athletic competition.” It is once again significant that this discussion of blood doping is located not in the chapter on doping in Sperryn’s book, but in a chapter on “Cardiovascular and Respiratory Systems.”

Given the date of publication of Sperryn’s book, it is perhaps surprising that he made no reference to any ethical issues in his discussion of blood doping for, by the late 1970s and early 1980s, sports physicians were increasingly raising the question of whether the technique, which they themselves had pioneered, might not give rise to ethical concerns relating to concepts of fairness and cheating. However, it should be emphasized that, particularly in the 1970s, most researchers appeared as unconcerned with ethical issues as were Williams and Sperryn. It might be noted that two research papers on blood doping that did explicitly raise ethical issues were those by Videman and Rytömaa (1977) and by M.H. Williams, Lindhjem, and Schuster (1978). However, in both cases, the ethical issues discussed related not to fair play and cheating, but to the rather different ethical issues, such as those relating to informed consent that are raised when using human subjects in experimental programs.

By the late 1970s and early 1980s, however, it was becoming increasingly common for researchers to discuss not only the technical aspects of blood doping, but also to raise
the question of whether or not blood doping could be regarded as a form of cheating (Gledhill, 1982; Gledhill & Froese, 1979; M.H. Williams, 1981). Writers at the time saw this as a difficult issue to resolve, not least because a similar effect to that obtained by blood doping could also be obtained by training at altitude, a practice allowed by all sports governing bodies (Gledhill & Froese, 1979, p. 25). M.H. Williams (1981, p. 61) concluded his brief discussion of ethical issues by calling on the governing bodies of sport to consider the matter:

Because it is an effective method of improving distance running performance, its place in the sports world should be determined by the various governing bodies.

By this time, it was clear, the status of blood doping was changing. From being a technique that, in the early 1970s, raised technical issues but not, for most researchers, issues of fairness, it had become a technique whose ethical status was now uncertain. It was not yet, however, unambiguously regarded as a form of cheating.

The most recent stage in the moral career of blood doping came with the decision by the IOC, following the 1984 Olympic Games, to ban the practice of blood doping. Once the IOC had taken this decision, the view that blood doping was a form of cheating quickly became established as the orthodoxy among practitioners of sports medicine. Thus in 1987, the American College of Sports Medicine issued a “position stand,” in which it stated that “It is the position of the American College of Sports Medicine that the use of blood doping as an ergogenic aid for athletic competition is unethical and unjustifiable” (1987, p. 340). The following year Dirix, writing in The Olympic Book of Sports Medicine, held that the procedures involved in blood doping “contravene the ethics of medicine and of sport” (1988, p. 674). There was still the occasional skeptical view, such as that expressed in 1988 by Nuzzo and Waller, who reminded their readers that training at high altitude can lead to an increase in red blood cells (RBC), and who also suggested that this could place athletes trained at low altitude at a disadvantage. They then went on to ask, “Should blood doping be permitted to make all competitors have equal RBC concentrations?” (1988, p. 148).

By this time, however, such views were rare. Much more common was the view expressed by Eriksson, Mellstrand, Peterson, and Renström (1990, p. 383) and by Cowan (1994, p. 327), who not only echoed the sentiment expressed earlier by Dirix, but who also used his precise words: “These procedures contravene the ethics of medicine and of sport.” Mottram (1988, p. 23) similarly held that “Apart from contravening the ethics of sport and medicine, this procedure carries tremendous risk to the individual recipient.” Macauley (1991, p. 83), writing in a book published for the Sports Council for Northern Ireland, described the technique of blood doping and then noted “It is of course banned,” as though the technique were so self-evidently a form of cheating that it was difficult to see how this issue could ever have been problematic. Rather more sophisticated was the position of Wadler and Hainline, who argued that blood doping

is unique in that the inability to detect its use, coupled with its clear-cut ergogenic potential, demands from the individual athlete a more profound ethical and moral decision. As with other drugs and methods of deception which are always available, the athlete is left with a choice—to embrace the meaning of the essence of sport, or to participate in the practice of winning at any cost. (1989, p. 176)

The argument may have been a little more sophisticated, but the message was the same: Blood doping is cheating.
By the late 1980s, then, a new moral orthodoxy in relation to blood doping had been established. By this time, sports physicians, acting not merely as technical experts but also as moral "policemen" charged with the responsibility of educating athletes about both the ethics and the medical dangers of using banned substances or techniques, were telling athletes in unambiguous terms that the use of blood doping was cheating and that this technique should not be used. It is a reasonable supposition that, when advising athletes in their care, they did not tell the athletes that it was they—the sports physicians—who had developed and refined this technique. It is not perhaps surprising that, within this context, sports physicians chose to ignore certain aspects of the history of blood doping. Thus Bob Goldman, in his *Death in the Locker Room II*, wrote in relation to blood doping that "Some athletes will go to any length to boost their endurance and performance" (Goldman & Klatz, 1992, p. 203). The implication of Goldman’s statement would seem to be that, if anyone is culpable in relation to the use of blood doping, then it is the athletes. One might easily get the impression from Goldman that it was the athletes themselves, rather than Goldman’s own colleagues within sports medicine, who had developed the technique.

Conclusion

It is a central part of the argument in this paper that, although sports physicians are often seen as experts who play a frontline role in the fight against "drug abuse" in sport, a closer examination of the development of sports medicine suggests the relationship between sports medicine and the use of drugs is rather more complex. In this regard, it is suggested that sports physicians, in the search for record-breaking and competition-winning performances, especially since 1945, have become increasingly involved not merely in the search for improved diets or training methods, but also in the development and use of performance-enhancing drugs and techniques, some of which have subsequently come to be defined as forms of cheating.

One important implication of this analysis is that, if we wish to understand the processes involved in what is almost certainly an increase in recent years in the illicit use by athletes of performance-enhancing drugs, then, as Armstrong (1991) has suggested, we need to shift our focus away from what has hitherto been an almost exclusive concentration on the athletes, and examine more closely the networks of relationships in which athletes are involved. Clearly, one aspect of this must involve a much closer examination of the relationships between athletes and sports physicians. The close interrelationship between sports medicine, sports science, and the development of what have come to be regarded as illicit drugs and techniques, was nicely brought out by Cramer in his report on the use of blood doping by the United States cycling team at the 1984 Olympics:

In the national euphoria after the games, no one thought to pry out any secrets. The US team had won nine medals, dominating the cycling events. "Great riders." "Great coach . . ." "Great bikes . . ." said the press, reporting the daisy chain of back pats. No one thought to add, "Great doctors." (1985, p. 23)

In 1988, the British medical journal, *The Lancet*, published an article with the title "Sports Medicine—Is There Lack of Control?" It suggested that although evidence of direct involvement of medical practitioners in the procurement and administration of hormones is lacking, their connivance with those who do so is obvious and their participation in blood doping is a matter of record.
It concluded that Members of the medical profession have long been concerned with the health and welfare of people in sport, but never have the stakes been so high. Evidence continues to grow that some are showing more interest in finding new ways of enhancing the performance of those in their charge than in their physical wellbeing. Surely steps must soon be taken to curb the activities of those few doctors practising on the fringe by bringing sports medicine beneath the umbrella of a recognised body within an accredited programme of professional training. (1988, p. 612)

With this comment, The Lancet was beginning to move toward a more adequate understanding of the relationship between sports medicine and the development and use of performance-enhancing drugs. In one major respect, however, The Lancet article did not properly come to grips with an important dimension of this relationship. In suggesting that the search for new, and by implication, unethical, means of enhancing performance is confined to a “few doctors practising on the fringe,” The Lancet failed to grasp a key aspect of modern sports medicine. A central argument of this paper has been that the growing involvement of sports physicians in high-performance sport has meant that the search for performance-enhancing substances and techniques—a search that has resulted in the development of some drugs and techniques whose use has been considered unethical—is not confined to a few fringe practitioners. Rather, it has become an increasingly important part of the task of practitioners of sports medicine. In this sense, what The Lancet saw as a problem concerning the lack of control of sports medicine is not a problem that is confined to the fringes of sports medicine but, on the contrary, one that goes to its very heart.

References

Notes

1Patricia Vertinsky (1990) has documented late-19th-century medical views concerning what kinds of physical activity were considered appropriate for girls and women. She notes that these views were used to justify practices that "prescribed and/or delimited levels of physical activity and restricted sporting opportunities" for females (p. 1). Tissié's concern with what he saw as the physiological dangers of overexertion was not confined to women, but also related to men.

2Todd (1987, p. 93) suggests that Ziegler obtained this information at the 1954 World Weightlifting Championships, whereas Voy (1991, p. 8) suggests that he obtained this information while acting as a member of the medical staff of the U.S. team at the 1956 World Games in Moscow. Both authors agree about his subsequent role in the development and use of anabolic steroids.

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Managing Social Change: A Process-Sociological Approach to understanding Organisational change within the National Health Service

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Managing social change: a process-sociological approach to understanding organisational change within the National Health Service

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Abstract Using the implementation of the Griffiths Report as an example, this paper examines the way in which sociologists and others have examined the process of managing change within the NHS. Several studies of Griffiths have documented a number of unintended consequences of its implementation but it is argued that none of these have adequately theorised these unintended outcomes of the policy implementation process. It is suggested that the process-sociological approach of Norbert Elias, and in particular his game models, enable us better to understand the complex interweaving of planned and unplanned processes which is involved in all processes of managed change.

Key words: Griffiths, Elias, organisational change, NHS.

Introduction

This article grows out of our earlier research¹ on the introduction, following the publication of the Griffiths Report in 1983, of general management into the National Health Service (NHS). Its object is not to present in detail the results of that research – that has been done elsewhere (Dopson 1994) – although reference will be made, when appropriate, to our findings. Rather, our central object is to address some of the more theoretical issues involved in the analysis of what might be called ‘managed social change’, that is to say change which has been deliberately initiated with the specific objective of achieving some formally stated policy goal. In particular, we wish to argue that processes of managed change almost inevitably have unplanned outcomes, and to suggest that the process-sociological approach developed by Norbert Elias, and in particular Elias’s game models, may be
of some help in understanding such processes of managed change and, more especially, the relationship between planned and unplanned processes of change. Following a general discussion of the Griffiths Report and a brief review of studies of its implementation, we outline some particularly relevant aspects of Elias's process-sociological approach, including his development of game models. The article concludes with a case study from our own research, in which we drew on a games-model approach to shed light on the development of a policy designed to improve mental health services in one particular District.

The Griffiths Report and its critics

The changes associated with the Griffiths Report followed earlier major reorganisations of the NHS in 1974 and 1982. The Report identified what it claimed were five major problems within the management of the NHS. These problems, documented in the 'Observations' section of the Report, were a lack of strategic central direction, a lack of individual managerial responsibility leading to 'lowest common denominator' decisions, a failure to set clear objectives as a guide to managerial action, the absence of clear criteria against which performance could be measured and the absence of an orientation towards users of the NHS.

As a means of overcoming what it identified as problems, the Griffiths Report proposed a significant reorganisation of the NHS, including the establishment of an NHS Management Board reporting to a Health Service Supervisory Board whose role was to give clear strategic direction. This supervisory board was to have responsibility for the determination of the purpose, objectives and direction of the health service, for the approval of the overall budget and resource allocation, for strategic decisions for the service and for receiving reports on performance and other internal evaluations. A central innovation proposed by the Report, and one which was the subject of our earlier research, involved the introduction of general management. According to the Report, general management involved 'responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance' and the abandonment of formal consensus decision-making (DHSS 1983:11). General managers were to be 'the linchpin of dynamic management' and were cast as chief executives, providing leadership and capitalising on existing high levels of dedication and expertise amongst NHS staff. In addition, they were expected to stimulate 'initiative, urgency and vitality' amongst staff, to bring about a continual search for cost improvement, to motivate staff and to ensure that professional functions fed effectively into the general management process.

The Griffiths Report was subjected to critical examination by a number of writers. Day and Klein (1983), for example, suggested that the report
signified a change away from the mobilisation of consent and towards the management of conflict and they argued that if the health service was to move from a system based on the mobilisation of consent to one based on the management of conflict – from one that had conceded to a variety of interest groups the right to veto change to one that gives managers the right to override objections – then that process would mean radical and painful change. Davies (1987) saw the Griffiths report as an important part of a government strategy to gain a greater degree of centralised control and concluded that the report indicated that centralisation and the creation of a market in health care are not as opposed as they might at first seem. Petchey saw the report as transferring in an uncritical way managerial concepts from the private sector where, he suggested, management is less problematic than it is in the NHS because, in the former, 'there exists consensus about both the ultimate objective of the organisation (to make profits) and the criteria for evaluating alternative means of achieving that objective' (1986:92).

Implementing the Griffiths Report

In addition to these analyses, a number of more empirically based case studies have examined changes in the management of the NHS following the implementation of the Griffiths Report. Our own work was a study of this kind. Our main sources of data were 102 face-to-face interviews and 216 telephone interviews with twenty district general managers over a period of two-and-a-half years. In addition, we carried out interviews with district chairs, unit general managers, quality assurance managers and clinicians in twenty districts, together with direct observations of District Health Authority and District Board meetings.

Our research indicated that there were several unplanned and unanticipated outcomes of the implementation of the Griffiths proposals and, in some cases, these outcomes were the very reverse of the objectives set out in the Griffiths Report. Our major findings may be summarised as follows:

1. There appears to have been a trend towards greater centralisation of power within the health service, accompanied by increased bureaucracy, a proliferation of policy objectives and a shrinkage of resources, all of which served to curtail the freedom of those working at the district level to meet the health care needs of the local population.
2. There appears to have been more, rather than less, confusion in terms of accountability structures in the NHS. At the time they were appointed, the general managers in our study were extremely clear that they were accountable to their District Health Authority and, through it, to the local community. However, our data suggested that in the everyday practice of their job, the actions of District General Managers
were constrained, in particular, by three overlapping chains of accountability comprising: (i) the Secretary of State, and the chairs of the Regional and District Health Authorities; (ii) the DHSS, the Regional Health Authority and the District Health Authority and (iii) the Management Board and the Regional General Manager (RGM). These constraints had the effect of obscuring what the general managers originally perceived as their accountability to the public and also led them to play down, in relative terms, the involvement of nurses, trades unions and other local groups in the formation and implementation of policy.

3. At the district level, general managers had radically divergent views of both their own leadership role and of the place of professional, and in particular, medical, advice in the implementation of their agenda for change. There was also a significant relationship between general managers' views of how they should act in what was a new role within the NHS and their previous occupational experiences, with many managers drawing upon their previous experiences as a basis for structuring their new role.

4. The status and power of the nursing profession appears to have declined within the new managerial structure. Nurses were often given quality assurance roles which were frequently seen as 'non-jobs' and this was associated with reduced influence in shaping policy decisions.

5. Because general management was introduced at a time when the government, led by Margaret Thatcher, was seeking dramatically to reduce public expenditure, the introduction of general management became inextricably linked with the idea of cuts in public expenditure and, as a consequence, notions of improving the management process were often viewed cynically.

6. Doctors, as an established and powerful group within the NHS, remained largely sceptical about the introduction of general management and frequently saw it as part of a government strategy designed to undermine, if not the NHS itself, then certainly the conception of the NHS held by many doctors. They did not flock to take up general management posts as the government had hoped and were deeply suspicious of general management as a vehicle to improve health services. They did not see themselves as 'natural managers' as Griffiths believed would be the case.

7. Improvements in quality mainly took the form of improvements in 'hotel services' rather than in the quality of medical care. In part, this was because improvements in the former did not involve managers in challenging the power of clinicians, and in part, it was because they were easier to measure and could be taken as an indication of managerial 'success'.

Most of our findings are consistent with those of other researchers who have examined the impact of the changes introduced following the
Griffiths Report. For example, a project which was concerned with the evaluation of general management and which was carried out by the Trade Union Research Unit in 1987, found a management structure which was in many ways marked by confusion rather than clarity of managerial responsibility. Robinson et al. (1989) found that the new decision-making structure had resulted in the wholesale abolition of the established nursing hierarchy and that nurses were now in a ‘hotch-potch’ of jobs. Strong and Robinson (1990) found that ‘doctors still gave orders’ and that nursing had relatively little managerial importance. Kingston and Rowbottom (1989) described a situation characterised by confused roles, unworkable responsibilities, inadequate arrangements for accountability, proliferating committees and clumsy procedures.

This brief and, we readily acknowledge, selective overview of the consequences of the implementation of the Griffiths Report is not intended to be comprehensive. Neither is it our intention to suggest that the implementation of the Griffiths Report should, in some simplistic way, be deemed a failure. In this context it is relevant to point out that several studies concluded that decision-making following the introduction of general management had speeded up, though it is perhaps important to treat this finding with some caution since it is a finding about people’s perceptions of decision-making, not about decision-making as such. For example Harrison et al. (1992) found that managers in the areas of finance, personnel, planning and nursing were likely to believe that decision-making had speeded up, especially if they had previously worked at the regional level, whereas clinicians generally saw the district management team as having merely changed its name and reported no significant change in decision-making. However, we would reiterate that it is not our intention here either to provide a comprehensive summary of the consequences of the implementation of the Griffiths Report, or to offer a general evaluation of the effectiveness of general management. The point we wish to make is a more simple one, but one which raises an interesting problem in relation to how we can best analyse processes of managed social change.

The central issue on which we wish to focus is that all the research on general management, including our own, indicates that the implementation of general management did not work out in the way in which either Sir Roy Griffiths and his team or the Government had intended; there were, that is to say, a number of unanticipated consequences of the introduction of general management and, at least in some cases, those consequences were not only unexpected but were actually the very reverse of what had been intended and hoped for by those responsible for initiating these changes.

The question which immediately arises, therefore, is how we can account for what all studies have identified as a significant gap between the intentions and aspirations expressed in the Griffiths Report and what the introduction of general management was able to deliver. Many of
the empirical studies of general management have failed to pose this question, let alone provided an adequate answer. This may in part be a consequence of the funding arrangements for these studies and the interests of the funding bodies. It may also reflect the absence of helpful concepts or frameworks because of the general lack of interest of medical sociologists in health care management (Cox 1986) and the feeling amongst many academics working in the area of management studies that the health service is not a fruitful research and consultancy area, though this latter perception is now beginning to change, particularly since the introduction of the internal market in the NHS following the 1989 White Paper. Some of the studies of general management do, however, offer explanations for the gap between the objectives expressed in the Griffiths Report and what general management was able to deliver and, before offering our own framework for understanding such discrepancies, it may be useful to examine some of these alternative explanations.

Strong and Robinson, reporting on the implementation of the Griffiths Report in a sample of districts, concluded that the reason for the failure of general management to meet expectations was that, although the Griffiths model was a radical one, it was implemented within an institution which had a very different tradition of central planning. They argue that, as a consequence, the changes following the Griffiths Report represented only a partial break with the past and that general management was, as they put it, 'trapped inside the old NHS hierarchy' with what they describe as continuing 'political interference'. They concluded:

whereas writers such as Drucker had urged 'socialist competition' for this special type of service institution, the NHS remained monolith. Griffiths might have installed a line of command and imposed a micro-management ethos but it had left its macro-structure intact (1990:183).

Sir Roy Griffiths himself hinted at the problems associated with such a compromise in a public lecture in 1991. He indicated that change had not occurred as fast as he would have liked and suggested that this had been largely because of poor leadership from the Supervisory Board and the Management Board. Both, he argued, 'were absolutely correct in concept' but were 'half-hearted in their implementation'. Major policy issues, he suggested, were left uncovered; there was no proper attempt to establish objectives for the Health Service as a whole and no concentration on outcomes (1991:12).

In addition, Strong and Robinson argued that local processes also affected the transition between the old and the new styles of management. In particular, they point to the way that previous structures had sometimes foreshadowed the new regime, to the fact that the old district management team still existed and moulded events, and to the influence of the new District General Managers' differing backgrounds and preferred styles of working. These points are unfortunately not elaborated.
McNulty (1989) found that conflict between clinicians and managers – conflict which was associated with the very different cultural assumptions held by these groups – substantially reduced managerial effectiveness and made it difficult for managers to achieve the changes which they desired. Harrison et al. explained the gap between what the Griffiths Report promised and what general management was able to deliver in terms of tensions or problems internal to the Griffiths model. They highlighted in particular three key problems. First, they argued that the managerialism of the Griffiths model was founded on distrust and that this contrasted radically with the consensus mode of working, associated with the 1974 and 1982 reorganisations of the NHS, which rested on trust. They wrote:

to transform such a system into one in which identifiable individuals have to take personal responsibility for quantified targets, is to shine a strong, harsh light into processes of intricate political bargaining which may require degrees of flexibility, creative ambiguity and even downright secrecy in order to function most efficiently. This may be no bad thing, but it does cast doubt on the claim that Griffiths made to be able to preserve the good features (unidentified) of the consensus management system alongside the new model (1992:68).

A second problem identified by Harrison et al. was the failure of the Griffiths Report to offer a convincing analysis of the relationship between the business of running the NHS and the workings of the political system within which the service is set:

The NHS is a major, and highly popular public institution. It generates the never-ending stream of issues of local or national political interest. Underpaid 'angels' (nurses or ambulance staff); new wonder treatments; lengthening waiting lists; doctors with controversial diagnostic approaches to children who are suspected of having been sexually abused, other children who are kept waiting for treatment for life-threatening conditions because of staff shortages; scandalous conditions in long-stay geriatric or mental hospitals – the list is endless. Ministers have seldom been able to resist the pressures to intervene when one of these issues flares up, and there is no obvious reason to expect they will exert greater self-restraint in the future (1992:69).

Finally, Harrison et al. argued that the revolution in managerial culture proposed by Griffiths was posited on the development of tolerably clear objectives, which simply did not emerge. They concluded that:

the implementation of the Griffiths model has been handicapped by tensions and limitations which were inherent in the original report, by flawed understanding of the management problems of the NHS and by
wider developments (the failure of government to set clear priorities, plus the deteriorating financial situation) which were beyond its remit (1992:72).

Harrison et al. develop a theoretical perspective drawn from political science in which concepts of power, organisational culture and puzzlement or uncertainty are to the fore in explaining the relationships between doctors and managers and the problems general managers faced in implementing general management policies within the NHS. The first chapter of their book is devoted to an explanation of these key concepts, but the book is disappointing in the sense that there is no overt attempt to apply these concepts to their data on general management. For example, in summarising the reasons for what might be called the 'implementation gap' Harrison et al. do not draw explicitly on the three explanatory concepts they set out earlier in their book. Rather, they state:

implementation failure is not necessarily the fault of general management. Indeed, in some of our districts, general managers struggled against all the odds to make progress. The fact that they either failed or were only partially successful has less to do with general management per se than with the prevailing culture, resource context, organisational relationships (both intra- and inter-), uncertainties in the external environment and the power dependencies among key groups or stakeholders. They conspired to act as a more powerful determinant of policy implementation than general management. Where successful progress was possible in particular local circumstances, the converse prevailed though instances of this were, given the complexities, understandably more rare (1992:112).

Many of these studies shed helpful light on the 'implementation gap', and our own work confirmed the importance of several processes identified in other studies. For example, our sample of general managers identified the difficulty of dealing with doctors – the 'problem of doctors' as the managers saw it – as perhaps the greatest single difficulty with which they had to cope, though it should be noted that our interviews with clinicians also indicated that what from the point of view of managers was the 'problem of doctors' was, from the point of view of doctors, the 'problem of managers'. We also agree that there were major problems in the relatively uncritical transfer to a politically sensitive public service such as the NHS of managerial concepts and strategies which had been developed in the rather different context of private industry. However, while we accept that many of these studies provide, to a greater or lesser degree, useful analyses of the 'implementation gap' within a particular organisation during a particular period of time, we would argue that none of them provides a model which offers an adequate understanding,
on a more theoretical level, of the processes involved. We would further argue that such a general model is required for, without a continual interdependence – Elias referred to ‘an uninterrupted two-way traffic’ (1987a:20) – between the development of detailed knowledge and synthesising models, the empirical and the theoretical, the collection of detailed knowledge of particular situations will be of limited use, for it is only by the use of synthesising models that we can generalise from one situation to another, and only by means of constant checking against empirical results that we can test the adequacy of our synthesising models.

Underlying not only the Griffiths Report but also the work of many writers who have analysed the implementation of that report, is an implicit assumption that with ‘proper’ information and ‘sound’ management it is possible to implement change in such a way that the outcome, within relatively closely defined limits, will be more or less what was intended. The Griffiths Committee, for example, clearly imagined that it was possible to implement the recommendations in such a way that the desired outcome would be achieved and when this desired outcome was not achieved, the implementation gap was attributed largely to what might be termed failures or errors, for example poor leadership, half-hearted implementation and the absence of a ‘proper’ attempt to establish objectives for the health service as a whole. In contrast to Griffiths’ own explanation (1991), which rather suggests that if everyone had tried harder and done their job properly then the implementation would have been much more of a success, a number of other analyses, and particularly the sociologically more satisfactory ones, have focused upon social rather than individual processes, some of which involve socially structured tensions or conflicts which have impeded a fuller and more effective implementation of the Griffiths proposals (Cox, 1991, Strong and Robinson 1990, Harrison et al. 1992, Pettigre et al. 1992). However even these rather more satisfactory analyses do not adequately theorise the unintended outcomes of the policy implementation process and, in particular, none of these approaches offers a general explanatory model which suggests that such an implementation gap should be regarded as the norm rather than as something unexpected. It is precisely in order to theorise more adequately this aspect of managed change that we have drawn upon the work of Norbert Elias, and in particular, on his game models.

Elias sees game models as a means of isolating in close focus the intertwining of the aims and actions of pluralities of people, thereby making these complex processes of interweaving more easily understandable (1978:73). On a theoretical level the game models, like Elias’s more general process-sociological approach of which they are a part, are designed as a way of helping to move towards a resolution of the age-old problem within sociology which has variously been described as the relationship between the individual and society, free will and determinism, personality
and social structure or, in its currently popular formulation, the agency/structure debate. In this regard, Elias's approach recognises that human action is, to a greater or lesser degree, consciously directed towards achieving certain goals and that all human action necessarily involves both cognition and emotion, and in this sense it fully takes into account the fact that humans are thinking and feeling animals, and that, in a highly individualised society such as modern Britain, we each have our own more or less individual pattern of intentions, preferences and desires. At the same time, however, Elias also emphasises that the outcomes of complex social processes cannot be explained simply in terms of the intentions of individuals; indeed, it is important to recognise that the normal result of complex processes involving the interweaving of the more-or-less goal-directed actions of large numbers of people includes outcomes which no-one has chosen and no-one has designed. Social processes of this kind, involving outcomes which were unplanned and unforeseen, Elias termed 'blind social processes' (1987a:99). Before we examine Elias's development and use of game models, it may be useful to say a little more about Elias's concept of blind social processes and the relationship between blind and planned processes of change.

Blind social processes and the planning process

Elias has pointed out that it is possible to identify a number of long-term social processes which were unplanned but which involved change in a particular direction. A good example is provided by Elias's own work (1978a, 1982) on civilising processes but there are numerous other examples which one could cite. One of the most obvious is the long-term trend towards the increasing differentiation of social functions. The aspect of this process which has been most studied by social scientists is probably that involving the increasing division of labour, a trend the existence of which can be verified relatively easily, for example by comparing the number of occupational groups designated by a special term in societies at different stages of social development. However, it should be noted that the trends towards a growing differentiation of social functions does not simply involve a growing division of labour, but is much more all-embracing and can be observed not only in the production of goods but in the administration of states, in science and technology and in almost all areas of social life. As further examples of long-term unplanned processes, one might mention the lengthening of chains of interdependency – a process which Elias analysed in some detail in The Civilizing Process and which involves a greater number of people, over greater geographical areas, becoming increasingly interdependent – or, perhaps rather more familiar to most people, processes involving the routinisation or secularisation of many aspects of social life.
What, then, for those involved in managing change, is the relevance of an understanding of longer-term, unplanned processes? In this context, it is important to remind ourselves that, as Elias has noted, the steady growth of more conscious and deliberate attempts to manage processes of change through the growth of institutionalised forms of social planning is a development which is characteristic of a specific phase of a broader unplanned development (1977:138-9). Yet those involved in designing and implementing processes of managed social change hardly ever bother to ask questions about the long-term, unplanned structural changes in human societies which have provided the basis, particularly in the twentieth century, for the rapid growth of precisely those kind of planning projects in which they are themselves involved.

To a considerable degree, this failure to recognise the long-term interweaving of planned and unplanned processes is a consequence of the fact that those involved in planning are all too often involved in networks of relationships which constrain them to deliver results in the short-term. Almost all research concerned with the management of change — and this is perhaps particularly true of recent research concerned with managing change within the NHS — is very much concerned with the here and now. This present-orientation — Elias (1987b) called it the 'retreat into the present' — is often justified in terms of a dichotomy which emphasises the practical rather than the theoretical, with the implication that such a 'practical', present-centred orientation provides a better guide to planning. It is however difficult to see any reasonable basis on which such a claim could be sustained and, indeed, it is perhaps particularly when considering the practical relevance of sociological studies that one sees most clearly the limited value of a sociology which is concerned exclusively with the here and now. Underpinning such present-centred research, as Elias noted, is an almost complete lack of awareness of the long-term unplanned developments which have created the conditions that have made possible a greater degree of deliberate planning and within which all planned projects take place. There are clearly considerable risks involved in social planning which is based exclusively on present-centred, here and now investigations. Elias pointed out, for example, that it is only through striving to understand long-term processes that we can move towards obtaining an orientation that is sufficiently wide-ranging and reality-congruent to enable us to decide whether short-term practical measures designed to overcome difficulties and disadvantages will not, in the longer term, produce difficulties and disadvantages that are even greater (1977:138). A fuller understanding of the way in which the actions of interdependent people interweave to produce trends which no one has planned or intended, and which then constitute and constrain the perceptions, goals and actions of people, can only be adequately understood if we take a longer-term developmental perspective. As another process-sociologist, Johan Goudsblom, has nicely put it, 'in the development of
human societies, yesterday's unintended social consequences are today's unintended social conditions of "intentional human actions"" (1977:149).

It might be objected that Elias's concept of blind or unplanned social processes involves nothing more than what has long been recognised by social scientists under another name. In this respect, it is true that the idea of unintended or unanticipated consequences of social action has a long history and that it may be found in the work of some classical sociologists and philosophers, while in economics it may be found — though in a specific and very limited way — in the work of free market advocates such as Hayek (1945). Within sociology, the idea of unanticipated consequences is probably most closely associated with the work of Robert Merton (1936, 1949). However, as Mennell (1989) has pointed out, there are some important differences between the concept of unanticipated consequences, as developed by Merton, and Elias's concept of blind social processes. Mennell points out that Merton focuses, in particular, on what may be regarded as an oddity of social life, namely the 'self-fulfilling' prophecy, with passing mention of the converse 'self-contradicting' prophecy. Such situations may have a certain fascination but they are, suggests Mennell, fundamentally a trivial diversion, because they are simply an unusual and rather special case of something which is not only much more common, but also of considerably greater theoretical significance. Mennell expresses what he sees as the major difference between Merton and Elias thus:

Much more clearly than Merton, Norbert Elias recognizes that people's knowledge of the figurations in which they are caught up is virtually always imperfect, incomplete and inaccurate. The strategies of action which they base on this inadequate knowledge therefore more often than not have consequences which they do not foresee. So unanticipated consequences are not a curious footnote to sociology but nearly universal in social life. For Merton, the self-fulfilling prophecy is like a boomerang: the consequences of men's (sic) actions rebound upon their initiators. For Elias, the analogy is much less exotic and much more commonplace: like the effect of a stone dropped into a pool, the consequences of people's actions ripple outwards through society until they are lost from sight. Their effects are felt, not at random but according to the structure of the figuration in which they are enmeshed, by people who may well be quite unknown to each other and unaware of their mutual interdependence (1989:258).

There is another, and perhaps more fundamental, difference between Elias's work and that of Merton. Whereas Merton's discussion of unintended consequences was largely individualistic, Elias's focus was on pluralities of people, for Elias was concerned not with single acts but with aggregates of intentional acts. The largely individualistic character of
Merton's position was explicitly recognised by Merton himself in his early classic article which, he acknowledged, dealt mainly 'with isolated purposive acts rather than with their integration into a coherent system of action' (1936:895). Though Merton's later (1949) discussion is perhaps less individualistic, it remains the case that Elias's approach focuses far more systematically, not on isolated individual acts, but on the complex interweaving of the actions of many people, not all of whom will even be known to each other.

At this stage it may be useful to turn to a more detailed examination of Elias's game models in order to see, in particular, how these can help us better to understand the complex interweaving of the actions of large numbers of people, and of planned and unplanned processes.

The Game Models

The game models are offered as simplified analogies of more complex social processes. The models help to bring out more graphically the processual character of relationships between interdependent people while they also focus attention, in particular, on changing balances of power, or power-ratios, as a central aspect of the web of human relations; in this context, it should be borne in mind that games are contests and that all the game models are based on two or more people measuring their strength against each other. Power, conceptualised not as a property which one person or group has and another person or group does not have, but as a structural characteristic of all human relationships, is central to Elias's approach. Within the context of understanding processes of managed social change, the game models are useful precisely because they demonstrate that the outcomes of the complex interweaving of the actions of different players in the game, even where these actions are more or less consciously directed towards the attainment of certain goals, may include — in the case of complex games almost certainly will include — outcomes which no single player or group of players intended. Within the context of managing social change the 'game' is, of course, the game of implementing, or resisting the implementation of, a given policy strategy.

Elias's most simple game model involves just two people, one of whom is a much stronger player than the other. The stronger player can, to a very considerable degree, constrain the actions and limit the options of the weaker player to make certain moves, whereas the weaker player is much less able to constrain the actions of the stronger player. However, the weaker player does have some degree of control over the stronger for, in planning his or her own moves the stronger player has at least to take the weaker player's moves into account. In other words, in any game the participants always have, though in considerably varying degrees, some control over each other. Where the differential between the players'
strengths in the game (that is the balance of power or their power-ratio) is very great, the stronger player has not only a higher degree of control over his or her opponent but also a higher degree of control over the game as such. The stronger player is thus able significantly to control the course of the game, not only by winning, but also by determining the manner of the victory and perhaps the length of time taken. In a very simple game of this kind, we are able to understand the course of the game largely in terms of the goals and plans of the stronger player.

However, let us now consider a two-person game in which the two players are of roughly equal ability (i.e. of roughly equal power). As the differential between the strength of the players decreases, so the ability of the stronger player to force the weaker player to make certain moves diminishes, as does the stronger players’ ability to determine the course of the game. Correspondingly, the weaker player’s control over the stronger player increases but, as the power balance between the two players becomes less unequal, so the course of the game increasingly passes beyond the control of either. As Elias put it:

Both players will have correspondingly less chance to control the changing figuration of the game; and the less dependent will be the changing figuration of the game on the aims and plans for the course of the game which each player has formed by himself. The stronger, conversely, becomes the dependence of each of the two players' overall plans and of each of their moves on the changing figuration of the game – on the game process. The more the game comes to resemble a social process, the less it comes to resemble the implementation of an individual plan. In other words, to the extent that the inequality in the strengths of the two players diminishes, there will result from the interweaving of moves of two individual people a game process which neither of them has planned (1978:82 original emphasis).

Elias considers a variety of game models from, in increasing order of complexity, multi-person games at one level (e.g. in which one player may be playing simultaneously against several other players, or in which two sides each containing several players compete against each other) through to multi-person, multi-level games. In this latter group of game models, the number of players increases and the structure of the game becomes increasingly complex. In particular, in multi-level games, not all the players play directly with each other and moves may be made by specialised functionaries such as leaders, delegates, representatives, committees and governments, on an upper tier. In addition, while each side continues to struggle against the opposition, there may be more than two sides – indeed there may be many sides – involved in these games. Part of the increased complexity of the game relates to the fact that there are now several different balances of power which have to be taken into account:
among the top-tier players; between the top and lower-tier players; and among lower-tier players. The balance of power between the upper-tier and lower-tier players may be relatively unequal, in which case there is a relatively oligarchic game structure, or it may be relatively equal, in which case the game is relatively democratic. It is these more complex game models which are most useful for shedding light on complex processes in modern societies, such as the processes involved in, for example, planning and managing processes of social change.

It is important to note that, as the number of players and the complexity of the game increase, and as the power differentials between the players diminish, so the course of the game becomes increasingly unpredictable and increasingly beyond the ability of any single individual or group of players to control. We noted earlier that, in the case of a simple two-person game played between players of very unequal ability, the course of the game can be explained largely in terms of the plans and goals of the stronger player. However, as the number of interdependent players grows, it also becomes clear how little the game can be controlled and guided from any single player's or group's position; indeed, the opposite is the case, for it becomes clear how much the course of the game—which is actually the product of the interweaving moves of a large number of players—increasingly constrains the moves of every single player. The development and direction of the game become more and more opaque to the individual player and, within this context, it becomes increasingly difficult for any player or group of players to put together an accurate mental picture of the course of the game as a whole. However strong the individual may be, he or she will become less and less able to control the moves of other players and the course of the game and, from the point of view of the individual player, an intertwining network of more and more players functions increasingly as though it had a life of its own. In summary, the game models, and in particular the more complex models:

indicate the conditions under which players may slowly begin to encounter a problem: that a game process, which comes about entirely as a result of the interweaving of the individual moves of many players, takes a course which none of the individual players has planned, determined or anticipated (1978b:95 original emphasis).

Although there is a rapidly growing volume of sociological literature which draws upon the work of Elias, very little has been written specifically about organisational change from a process-sociological perspective. Amongst the limited range of literature dealing with what might broadly be called organisational issues from such a perspective one might mention Dunning and Sheard's study of the bi-furcation of Rugby Union and Rugby League (1976), Waddington's study of the campaign for medical reform in Britain (1973, 1977), De Swaan's study of the welfare state
(1988) and Mastenbroek's study of conflict management and organisational change (1987). In addition, Williams et al. in *Hooligans Abroad* (1984), drew upon the games model approach in order to develop a scheme for limiting the occurrence of hooligan behaviour by English football fans at matches abroad. That such a framework may generate useful insights in relation to social policy issues is suggested by the fact that the scheme was warmly received by the Football Association and the Football Trust and was recommended by a working party at the Department of the Environment as providing a viable basis for developing a counter-hooligan strategy. An Eliasian framework has not, however, previously been applied to the analysis of managerial issues within the NHS and, given this situation, it may be useful to say a little more about our own work which was concerned with the introduction of general management into the NHS.

Case study: the development of a mental health policy

Part of our earlier study documented how a District General Manager (DGM) sought to improve mental health services in his district and the problems he encountered. Part of the analysis counterposed the DGM's relatively involved perception of these problems with an understanding of these problems as revealed by a relatively detached, sociological analysis.

In the district under examination, the development of a comprehensive mental health strategy became a priority partly as a consequence of actions by key players outside the district, for the mental health services in the district had recently been severely criticised in a report from the Health Advisory Service, while the Royal College of Psychiatrists had also expressed concern about the quality of training available within the district. The DGM saw the development of a mental health strategy as a means not only of improving the embarrassingly poor mental health services in the district, but also as a means of demonstrating the effectiveness of the new management structure. Together with a core group of his senior managers, the DGM developed a strategy which centred on five services/client groups: acute psychiatric services, rehabilitation, services for the elderly mentally ill, child and adolescent psychiatry, and drug and alcohol abuse. The strategy as a whole involved a shift away from hospital-based towards community-based care and a central aspect of the strategy involved the resettlement in the community of some seventy residents of a long-stay psychiatric hospital. This resettlement programme was central to the plan to re-shape the service, not least because it was to provide the additional resources needed to build up the community-based services.

Throughout the process of developing and implementing the mental health strategy, we monitored the complex discussions and negotiations in which the DGM and his core management team were involved with groups both inside and outside the district. Following the implementation
of the strategy, and at our request, the DGM wrote a brief evaluation of
the implementation of the mental health strategy. He acknowledged that
the strategy had had very limited success in effecting a shift away from
hospital-based and towards community-based services, largely because the
plan to resettle some seventy residents of a long-stay psychiatric hospital
- which was, as we have noted, central to the success of the wider strat­
egy - had been vigorously opposed, in particular, by psychiatric consul­
tants and by some groups within the local community. As a consequence,
only fourteen patients were resettled in a local hostel and a further seven
in a terraced house in the district. Of equal sociological interest, however,
is the fact that we were able to identify a number of unintended conse­
quences -of which more will be said shortly; none of which were
mentioned by the DGM in his own evaluation of the strategy and of which
he seemed to be either unaware or, at best, only partially aware.

In seeking to understand the way in which the mental health strategy
was developed and implemented, we found it useful to draw upon Elias's
game models. In particular, the model of a complex game involving many
players (or groups of players) on several levels helps to highlight two cen­
trally important points which it is helpful to bear in mind when studying
the policy process. The first of these is that, in complex games, there are
likely to be not merely two sides, but several sides, and - except in very
rare situations where some players are able to stand back and take a rela­
tively detached view of the game - players will normally find it difficult to
understand the course of the game as a whole, but will have a more lim­
ited understanding of the game from their own perspective. As we noted
earlier, it is important to emphasise that games are contests and that the
game models are trials of strength, and in this respect the game models
help to steer us away from consensualist models of management, and to
emphasise the fact that, particularly within complex organisations, differ­
ent groups are likely to pursue what they perceive as their own interests,
and that these may or may not coincide, or may coincide only very par­
tially, with the perceived self-interests of other groups.

This point may be illustrated by reference to our own case study. On a
simple level, one might say that the objective of the mental health strat­
egy was to develop a better mental health service. However, such a state­
ment is underpinned by consensualist assumptions, and if we begin to ask
what this meant to the many groups involved then we begin to under­
stand the complexity of the situation and some of the tensions and con­
licts which were involved. As we noted, the proposed move towards a
more community-based service was resisted by the psychiatrists, who saw
it as a very direct and real threat to the continued provision of psychi­
atric beds. For them, a 'better' mental health service was one which
maintained and expanded their already powerful position as the domi­
nant group within this health care area; a 'better' service, in their view,
would involve not the loss of hospital beds, but the provision of more
facilities to improve the quality of care in hospitals which were, of course, a major power base for the psychiatrists. On the other hand, a ‘better’ service for the paramedical (e.g. community nursing) and social services professions was one which would allow them to play a fuller part in the treatment process which had traditionally been jealously guarded by the psychiatrists; hence there was a general welcome by the former for community-based care. For many members of the local community, who perceived the plan to relocate long-term patients in the community as a potential threat to the peace and security of local people, a ‘better’ mental health service was one which kept mental patients in secure accommodation away from the community. And for the DGM and his management team, a ‘better’ service was one which offered what they considered to be ‘good value for money’, which was in line with the policy of the government and the Regional Health Authority to develop community care and which would, in addition, demonstrate their own effectiveness and that of the new management structure.

The second point to which a complex game model draws attention is that the game is played by players on several different levels, or tiers, and that while all players are interdependent and therefore constrain each others’ actions, higher-tier players have more power over lower-tier players than vice-versa. In addition, it is important to note that upper-tier players do not necessarily play directly with lower-tier players. Thus, for example, in our study upper-tier players outside the district, such as members of the Health Advisory Service, or members of the Royal College of Psychiatrists, did not play directly with lower-tier players such as community nurses or members of the local community, though the actions of the latter were nevertheless significantly constrained by those of the former.

Players on the top tier were all located outside the district level and included, in addition to members of the Health Advisory Service and the Royal College of Psychiatrists, those involved in the formulation of health care policy at the national Government and Regional Health Authority levels. As we have already noted, a major constraint on the newly appointed DGM to develop a mental health care strategy came from the adverse report from the Health Advisory Service, coupled with pressure from the Royal College of Psychiatrists. Within the district, the DGM and his senior managers were top-tier players, along with the Chair and other members of the District Health Authority and, of central importance, the psychiatrists. Lower-tier players included members of the para-medical professions, local authority social workers, the Community Health Council, voluntary sector organisations, including the National Association for Mental Health (MIND) and, of course, lay members of the local community.

The complexity of the NHS, in terms of the number of groups involved and in terms of the shifting balances of power between those groups, means that any process of change is likely to involve a challenge to the
self-perceived interests of one group or another. It is also important to emphasise that the capacity of some groups to shape or to resist change is greater than that of others. In our case study it was the psychiatrists who were, at the district level, the most powerful group and, insofar as any group emerged as ‘winners’, it is probably fair to say that it was the psychiatrists who, by virtue of their more or less successful resistance to the resettlement strategy, did so.

It is worth saying a little more about the involvement of the psychiatrists in the policy process. During the early period of the formation of the policy – and despite the efforts of the DGM to involve them in this process – the psychiatrists played only a limited role. For the most part, they chose not to become involved in what they saw as a relatively low status and largely administrative activity, and preferred to concentrate on what, in their view, they were trained to do, what they enjoyed doing and what they were paid to do: doctoring. As they began to perceive the emerging policy as a threat to their interests, however, they became increasingly involved in the policy process and though psychiatrists are, perhaps, one of the less powerful groups within the medical profession they were, within this figuration, still relatively powerful. On several occasions, their refusal to cooperate delayed approval of the emerging strategy and they also frequently by-passed the DGM, and made their objections to the strategy known directly to the Chair of the District Health Authority. In making these objections, they were able to draw upon well-rehearsed arguments involving an emphasis on clinical autonomy, the importance of trained medical opinion and the erosion of beds. Their intervention in this policy process came, as we noted, relatively late, signifying their general lack of interest in management issues. However, the consequences of their intervention, when it came, were an index of their power in this figuration. It is significant that several groups of lower-tier players played a significant role in the early stages of the consultation process and were key players until the psychiatrists’ concerns came to the fore, at which point the lower-tier status of the other players became very clear, and their ability to influence the policy process became much reduced.

It is also important to bear in mind that balances of power are not fixed and unchanging but that, on the contrary, they are continually in flux. This means that it should not be assumed that lower-tier players are always more or less passive spectators of a game which is played out, as it were, above their heads, for all players have some power and lower-tier players may, under certain circumstances – for example, insofar as scattered and relatively disorganised lower-tier layers become increasingly unified and better organised – significantly increase their power chances vis-à-vis some upper-tier players. A case in point was provided in our case study by those sections of the local community who, not without success, opposed the resettlement of psychiatric patients in the community.
Within the NHS, local communities are represented, in a formal sense, by Community Health Councils (CHCs). In this case the local community, through the CHC, was consulted about the mental health strategy in the time-honoured tradition of the NHS, namely through the receipt of a weighty strategy document. However, the DGM did not receive via the CHC any indication of the widespread anger within the community about the proposal to use three local houses to rehouse the psychiatric patients. This suggests not only that the CHC did not represent the local community very effectively but also that, at least in the early stages of the policy process, local community groups, as lower-tier players, were largely ignored by the district management team. However, local residents developed their own ad hoc organisation to campaign against the resettlement proposal. Public meetings were organised, the local press became involved and the DGM, who admitted that he was taken by surprise by the strength of the community's opposition, was forced to reconsider – and eventually substantially to amend – the strategy. It should of course be remembered that members of the local community were not alone in campaigning against the resettlement programme for, as we have noted, this programme was also opposed, for rather different reasons, by the psychiatrists. However, the fact that the local community played an important part in undermining the resettlement strategy serves as an important reminder that even lower-tier players are not wholly powerless.

Our case study serves to illustrate a number of points. The first of these is that the policy process rarely follows the neat, rational models of change set out in some of the management literature (for a review of the theoretical approaches to managing change, see Legge 1984 and Spurgeon and Barwell 1991). Attempts to change policy are considerably more complex and messy than this literature suggests and are almost always characterised by unintended outcomes. In the case of the mental health strategy, it should be noted that the strategy had been developed by the DGM and his team with a view to achieving a number of objectives, including the following: shifting the balance of care away from a hospital-based service; developing the local community as a resource in the provision of psychiatric care; reducing the centrality of psychiatrists and increasing the involvement of the social work and para-professions in the provision of care; and – by no means an unimportant consideration for the DGM – helping to establish his authority in his new role by demonstrating the effectiveness of the new management structure in bringing about significant improvements in care. However, the development and implementation of the strategy resulted in a number of outcomes some of which were more or less the opposite of those which had originally been intended. These unintended outcomes included the following: the power of doctors to influence the outcome of change was emphasised; the continued importance of the ‘hospital approach’ to mental health services was emphasised; many members of the local community became more
antagonistic towards plans for care in the community; members of the para-professions and social services were marginalised and disaffected; the power of the Chair of the DHA was emphasised at the expense of both the DGM and ordinary members of the DHA; and the authority of the DGM and the value of the new management structure were called into question, not just by those who were disappointed at the outcome and who felt that the consultation process had been a sham, but also by those – notably the psychiatrists and the local community – who had a greater influence on the outcome but between whom and the DGM relationships also became very strained.

The case study also illustrates several points which we made earlier. Unanticipated outcomes of the kind outlined above are a consequence of the complex interweaving of the actions of large numbers of people pursuing their own goals, but – as is almost always the situation in complex games involving large numbers of players – with no single group being sufficiently powerful to control the course of the game. Closely associated with the inability of any single group to control the game is the fact that, as the game becomes increasingly complex, it also becomes increasingly difficult for any single player or group of players to develop an accurate picture of the game as a whole, and each player is likely to have only a very partial understanding of the game from his/her own perspective.

This leads on to a further important implication of our case study, which is that people who are involved in developing and implementing policies rarely understand fully the constraints within which either they or other key players work and, as a consequence, they frequently misunderstand, or at best only very partially understand, the actions and intentions of other players. For example, part of our research involved asking some of the key players, including the DGM, other senior managers and the consultant psychiatrists, for their views on why the development of the new policy had encountered so many difficulties. Many of these explanations were notable for their individualistic or personality-centred character – for example, the ‘difficult personalities’ of the psychiatrists, or the alleged stubbornness or ineffectiveness of particular managers – and for the fact that they frequently indicated only a very limited understanding of the way in which people’s actions were constrained by broader social processes. In other words, most players were too involved in the game – that is, the political struggle – to take what Elias called a detour via detachment (1987a:105–6), to stand back and to analyse their own and other people’s actions, not from their own relatively involved perspective, but from a relatively detached position. Within the heat of the immediate struggle it is, of course, not easy to stand back and try to develop such a relatively detached view, though it is worth nothing that those managers who are able to do so will almost certainly encounter fewer problems and will also enhance their chances of achieving rather more of their stated goals.
A further implication of the above is that those studies of health care management which have as their main source of data what individual managers say about health care management are seriously flawed. Views such as those expressed by the DGM in our study— that change was hard to achieve largely because of the obstinate personalities of the psychiatrists— should be treated not as an explanation, but as data to be explained. Quite clearly, if players such as our DGM had an adequate understanding of processes of organisational change, there would be no need for sociological analysis. Data which take the form of the relatively involved perceptions of participants need to be complemented, not just by accounts from other key players, but also by a relatively detached examination of the complex figurations in which all these people work. The policy process involves many people at different levels within and outside the organisation, and the extent to which different groups are committed to or opposed to the prevailing policy, and the strategies which they adopt in relation to that policy, play an important part in determining its outcome. However, the perspectives of the players in relation to these issues should be treated not as detailed analyses, but as more or less involved expressions of their own perceived interests. A properly sociological analysis should, therefore, seek to explain those perspectives in terms of the players' specific positions within the figuration of relationships amongst those involved in the policy process.

Conclusion

One of our main objectives in this paper has been to set out an approach which, we believe, more adequately than existing approaches theorises what is a common aspect of managed change, namely unplanned outcomes. Throughout this paper we have continually stressed the complex interweaving of planned and unplanned processes, and have suggested that Elias's game models provide a means of temporarily isolating and focusing upon these complex processes of interweaving, thereby making them more easily understandable. However, the fact that we have argued that processes of managed change almost inevitably have unplanned outcomes does not mean that we see planning as a futile process, or that we oppose the principle of planning; indeed, the reverse is actually the case, for we are both firm believers in the necessity for planning if we are to overcome the major social problems, including the provision of adequate health care to all our citizens, which confront us in the late twentieth century.

It might be felt that our commitment to planning fits uneasily alongside what might be interpreted as a sceptical view of planning outlined in this paper. We would suggest, however, that what we have set out should be seen not as a sceptical, but as a realistic, view of planning. In this context, we are acutely aware of the fact that, as Elias pointed out, our knowledge
of and our ability to control 'natural' processes are considerably more
developed than are our knowledge of and our ability to control social
processes. We believe furthermore that it is important—and it is perhaps
especially important for those involved in the planning process—to be real-
stic about the limitations of our ability, within the constraints imposed by
our current knowledge, to control social processes. To recognise the limits
of our ability to control planned processes is not, however, to suggest that
we have no control, nor does it undermine the case for planning any more
than a recognition, for example, of the limited effectiveness of radiotherapy
as a means of treating certain forms of cancer indicates that we should
abandon radiotherapy altogether. In each case the appropriate course of
action is not to abandon those strategies which currently have limited suc-
cess, but rather to seek to make them more effective. We hope that this
paper will be seen as a contribution of this kind.

Given what we have said about unplanned outcomes, it is clearly
imperative that a systematic process of monitoring should be built into all
policy implementation from the outset; if we do not monitor the conse-
quences of the implementation of policy then we can have no clear idea
of the degree to which, if at all, we are achieving our policy goals and, as
we have argued, it is certainly foolish to assume that a policy designed to
achieve certain goals actually achieves those goals and that it does not
have other consequences which may, perhaps, be the very reverse of what
was intended. We recognise that this may seem little more than a state-
ment of the obvious, but we are continually surprised by the lack of sys-
tematic monitoring which is often characteristic even of large-scale
planned projects, and of the tendency, perhaps when funding becomes
tight, to assume that the monitoring process can safely be cut back with-
out any significant damage to the project. We would argue that, on the
contrary, any economies which may be sought by cutting back on the
monitoring process are likely to be false economies, and that monitoring
should be at the very heart of policy implementation. Only by systematic
monitoring can we know whether or not, or the degree to which, the pol-
cy goals are being achieved, and only then, armed with this knowledge,
can we initiate appropriate remedial action.

We do not of course assume that such remedial action is any less prob-
lematic than the implementation of the original policy, for any remedial
action is itself also likely to have unplanned outcomes. However, the
recognition that this process is a complex one, and that our ability to
control outcomes is limited, does not constitute a legitimate reason for
abandoning the planning process. Indeed, we would suggest that a recogni-
tion of our currently relatively limited control over social processes is,
insofar as it represents a relatively detached and more adequate appraisal
of the situation, a first step towards improving that control.

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Notes

1 This research was carried out by Sue Dopson for her PhD thesis at Leicester University. The research was supervised by Ivan Waddington.

2 The reorganisation of the NHS in 1974 involved the creation of three tiers of management under the Department of Health, comprising regional, area and district health authorities. Each district health authority was responsible for providing the full range of medical services. At each level was a consensus management team involving a nursing officer, a finance officer, an administrator, a specialist in community medicine and a representative of hospital consultants and general practitioners. The second reorganisation of 1984 retained the consensus management teams but removed the area tier. Just as the dust of this reorganisation began to settle, general management was introduced in 1983, the most significant feature of which was the appointment of general managers who led the management team at each level of the NHS. This person could be drawn from any background and, significantly, could previously have had a career entirely outside of the NHS. The most recent reorganisation has involved the introduction of an internal market for health care within the NHS.

3 Though it is not directly relevant to our concerns in this paper, it might be noted that the Thatcher government did not succeed in reducing public expenditure, though it might be said that it had some success in containing its growth.

4 Free market economists argue that the most rational form of economic organisation is that which comes about as the unintended outcome of the actions of large numbers of people pursuing their own individual interests. We have no space to develop a detailed critique of this position here, but we would note that, if this were the case, planning would be very simple and unproblematic and would have extremely predictable outcomes, for we would simply have to decentralise all economic decision-making down to the individual level and await the inevitably successful outcome. Those in government must wish that economic planning were indeed so simple!

5 We are not arguing here from a positivistic position in which the sociologist is seen as the omniscient purveyor of 'objective' knowledge. Nothing could be further from the position advocated by Elias, who wrote not in terms of a dichotomy between 'objectivity' and 'subjectivity' but in terms of degrees of involvement and detachment and in terms of knowledge which has a relatively high or low degree of 'object adequacy' or 'reality-congruence'. Our claims for the object adequacy of the knowledge generated by sociologists are in fact very modest, for throughout this paper we have emphasised not how much, but how little, we know about the complex interweaving of social processes. We simply claim that, insofar as we are able to stand back and analyse in a relatively...
detached way the development and implementation of policy, this will help us to generate more adequate explanations than those offered by people who are, for one reason or another, unable to develop such a degree of detachment. We believe this is a reasonable claim which most sociologists would share.

References


SPORT AND HEALTH:
A SOCIOLOGICAL ANALYSIS

by

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Sport and Health: A Sociological Analysis

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The objects of this paper are threefold: (i) to outline and critically to examine the widely accepted idea that sport and exercise have beneficial consequences for health; (ii) to examine the different patterns of social relations associated with sport and exercise; and (iii) to examine some of the physiological consequences of these social differences, in terms of the rather different impacts which sport and exercise can have on health.

Sport, exercise and the healthy body ethos

There are probably few ideas which are as widely and uncritically accepted as that linking sport and exercise with good health. What is particularly striking about this ideology is its near universal acceptance across a range of societies for, in developing and developed societies, in capitalist and communist societies and in democratic and totalitarian societies, there is a broad consensus that "sport is good for you".

The ideology linking sport and health has a long history. In nineteenth century Britain, the birthplace of many modern sports, an ideology of athleticism which linked sport with health, both physical and "moral", was developed in the Victorian public schools (Mangan, 1981), while the promotion and maintenance of the health of schoolchildren has long been an area of concern to physical educators. Colquhoun and Kirk (1987:100), for example, note that when physical education was introduced as a subject in the elementary school curriculum in the early twentieth century, it "had the express purpose of improving the medical, physical and hygiene provision for children in schools". Throughout the inter-war period, The Health of the School Child, the annual report of the Chief Medical Officer of the Board of Education, regularly made reference to the importance of physical education for the health of schoolchildren, and the idea that sport and exercise are associated with health is widely known and accepted by British schoolchildren today; a recent study for the Sports Council (1995:128) noted that "the health and fitness message seems to be well known by children. Virtually all of them, 92% agreed that it was important to keep fit ... In addition, most children, 82%, agreed that they felt fit and healthy when they did sport and exercise". Not surprisingly, the idea that sport is health-promoting and even life-enhancing is one which is frequently stressed by those involved in sport; to quote the former Olympic gold medalist Sebastian Coe: "Sport is an integral part of a healthy lifestyle in today's society" (foreword to Mottram, 1988).

Such views have been endorsed in a variety of official and semi-official health publications. In 1988, The Nation's Health, a report from an independent team, noted that regular and moderate exercise has a number of health benefits while The Allied Dunbar National Fitness Survey (1992) and the Department of Health in its Health of the Nation (1993) similarly noted a number of health benefits associated with regular physical activity.
Such statements are not confined to Britain. In 1993 an authoritative report from the American College of Sports Medicine and the Center for Disease Control recommended that adults should take 30 minutes of moderate activity on most days of the week (Wimbush, 1994). Nor are such views limited to capitalist societies, or to countries in the developed world. Riordan, for example, has pointed out that governments in developing societies frequently place considerable stress on the development of sport, not only for the consequences which sport can have for nation-building and national integration but also for the effects it can have on hygiene and health; indeed, Riordan (1986: 291) argues that "of all the functions of state-run sport in modernising societies, that to promote and maintain health must take first place", and he goes on to point out that "in many such states sport comes under the aegis of the health ministry". Elsewhere, Riordan (1981: 18) has pointed out that, following the Bolshevik Revolution in October 1917, the new Soviet Government saw regular participation in physical exercise as "one - relatively inexpensive but effective - means of improving health standards rapidly and a channel by which to educate people in hygiene, nutrition and exercise". Similarly, following the victory of the communists in China in 1949, emphasis was placed "on the need to promote national sports, expand public health and medical work, and safe-guard the health of mothers, infants and children". This policy, which dates from 1950, was endorsed by Mao in June 1952 when he called upon the Chinese people to "promote physical culture and sport, and build up the people's health" (Clumpner & Pendleton, 1981: 111).

However, it might be noted that although the ideology linking sport and health is very widespread, the view that sport is good for health has only relatively recently come to be applied to women as well as men for, during much of the 19th century, women were actively discouraged from taking part in vigorous exercise, which was often seen as damaging to their health. Patricia Vertinsky (1990: 39) in describing the situation in late 19th century Britain, writes:

The widespread notion that women were chronically weak and had only finite mental and physical energy because of menstruation had a strong effect upon the medical profession's and consequently the public's attitude towards female exercise and sport.

She argues that:

Not infrequently, medically defined notions of optimal female health.... have justified the practice of viewing female physiological functions as requiring prescribed and/or delimited levels of physical activity and restricted sporting opportunities (Vertinsky 1990: 39, 1).

Sheila Fletcher (1987: 145) has similarly noted that women's growing participation in cycling, swimming, golf and hockey in the late 19th century was met with resistance from eugenists such as Dr Arabella Kenealy who, in 1899, argued that women were in danger of neutering themselves by over-indulgence in athletics. The resistance to women's full participation in sport has similarly been documented for nineteenth century New Zealand (Crawford, 1987), Canada (Lenskyj, 1987) and America (Vertinsky, 1987).
The ideology of healthism and victim blaming

It is perhaps not surprising that those involved in what is sometimes called the "fitness industry" have generally supported the idea that sport and exercise are health-promoting, though it might be noted that such people have frequently conflated the concepts of fitness, health and beauty as a means of more effectively marketing their services. Perhaps of rather greater importance however, since they directly affect every schoolchild in many countries in the developed world, have been recent developments in school physical education which have promoted the role of regular physical activity in achieving and maintaining health. In this context, Colquhoun (1991:5) has written of an "explosion" of interest from the physical education profession in teaching health related issues, an explosion which, he suggests, is indicated by the burgeoning number of professional articles and curriculum guides in several countries, especially Britain, Australia, Canada and the USA.

This is of course not a new role for physical education which, as we saw earlier, has had an association with health and medicine reaching back to the introduction of physical education in the primary school curriculum in Britain. However, Kirk and Colquhoun have suggested that:

the recent re-emergence of health matters to occupy a place of central importance in school physical education marks a new moment in both the production of physical educators' views of their professional mission and in the production of a new health consciousness in society at large (1989:417).

Colquhoun and Kirk (1987) have identified several processes which, they suggest, have influenced this re-orientation of physical education towards health related issues, including a growing societal interest in health matters, the prevalence of heart disease and the spiralling costs of medical care; to these might be added the fact that many physical education teachers, perhaps conscious of the relatively low status of their subject vis-a-vis what are often considered more "academic" subjects, have been more than happy to draw upon the prestige associated with medicine and science to provide what they hope will be a more secure and "intellectual" basis for their subject.

However, Colquhoun (1991) has suggested that this emerging ideology of health based physical education (HBPE) is not unproblematic, for it presents a very partial and distorted view of the causes of health and illness. Drawing upon Crawford's (1980) concept of "healthism", Colquhoun argues that health based physical education is premised upon and helps to disseminate the idea that our health is largely under our own control. More specifically, he argues that:

by focusing on individual lifestyle as the major determinant of an individual's health, health based physical education (HBPE) conforms to the practices of conventional health education and has therefore been severely restricted in its potential for emancipation, social justice, equality and social change. Indeed, the political issues which accompany HBPE have not yet been fully exposed (1991:6).

The ideology of healthism, it is argued, serves to focus attention on individual responsibility for our own health and, simultaneously, to divert attention away from
wider social processes - for example, poverty, unemployment, industrial pollution, 
or the poor quality or lack of accessibility of health services - which may be 
associated with high levels of illness; by thus shifting responsibility for health away 
from manufacturers, governments and other powerful groups, the ideology of 
healthism diverts attention away from the key issues in the politics of health. As 
Crawford (1980:368) has noted, it perpetuates the misleading - or, at best, greatly 
oversimplified - idea that we can, as individuals, control our own existence. 
Moreover, our assumed ability individually to control our lives gradually becomes 
transformed into a moral imperative to do so, suggests Crawford (1984), we live 
in an era of a new health consciousness where to be unhealthy has come to signify 
individual moral laxity. Thus slimness signifies not only good health but also self-
discipline and moral responsibility whereas fatness, in contrast, signifies idleness, 
emotional weakness and moral turpitude. In this sense our bodies, whether slim or 
obese, signify not merely our health status for they also become, quite literally, the 
embodiment of moral propriety or laxity. Within this context, those who fall ill are 
increasingly likely to be seen not as unfortunate and innocent victims of processes 
beyond their control but, rather, as people who, through their moral laxity and lack 
of self-discipline, have "brought it on themselves". The Victorian differentiation 
between the "deserving" and the "undeserving" poor is, in some respects, in the 
process of being replicated in the differentiation between the "deserving" and 
"undeserving" sick.

Sport and Health: Commercial Links

One area which casts doubt on the assumed close relationship between sport and the 
promotion of healthy life-styles is that of sports sponsorship and, in particular, the 
widespread sponsorship of sport by the manufacturers of two of the most widely 
used drugs in the western world: alcohol and tobacco. In relation to the former, 
concern has been expressed about sponsorship of sport by breweries. Dealy (1990), 
for example, has drawn attention to the health problems associated with alcohol 
abuse and with the widespread practice of underage drinking in the United States 
and has expressed concern at the close relationship between the NCAA and the 
breweries. It is however the relationship between sport and the tobacco industry 
which has been the cause of greatest concern. Taylor (1985) has pointed out that 
since the 1970s, business sponsorship of sport has grown rapidly in Britain with the 
tobacco companies being by far the biggest spenders. Sports sponsorship is, he 
notes, a relatively cheap and highly cost-effective means of advertising for the 
tobacco companies, not least because in Britain it enables them to circumvent the 
1965 ban on the advertising of cigarettes on television, for cigarette manufacturers 
have continued to reach large television audiences via the televised coverage of such 
popular sporting events as the Embassy Snooker World Championships, Benson and 
Hedges Cricket and the Silk Cut Rugby League Challenge Cup. Sponsorship of 
sporting events by tobacco companies is now very widespread; sports which have 
been sponsored by tobacco companies in Britain include motor racing, power boat 
racing, cricket, speed-way, snooker, darts, bowls, horse-racing, tennis, rugby union, 
rugby league, basketball, badminton, show-jumping, motor cycling and table tennis. 
Sponsorship of sporting events by tobacco companies is, of course, not confined to 
Britain. In 1982 Dr Thomas Dadour introduced into the Western Australian 
parliament a bill to ban all forms of cigarette advertising and promotion. Had the
Bill been passed, one of the first casualties would have been the advertising at the 
Australia vs. England Test Match, which was sponsored by Benson and Hedges who 
had been the Australian Cricket Board’s main sponsor for more than ten years. The 
Bill was narrowly defeated. The following year, the state government of Western 
Australia introduced another Bill similar to Dr Dadour’s. This Bill was also defeated 
following intensive lobbying by, amongst others, those associated with the cigarette-
sponsored sports under threat (Taylor, 1985:48-9). In a more recent and perhaps 
even more revealing incident in 1995, the highly successful Swedish yacht Nicorette, 
which is sponsored by a company which manufactures products designed to help 
people give up smoking, was banned from the Cape to Rio Race, which is sponsored 
by the tobacco giant Rothmans. The captain of the Nicorette protested against the 
decision (which was reversed some two weeks later) by saying that "Rothmans is 
scared of his boat and the healthy lifestyle it seeks to promote". Given the close 
relationship which is often claimed between sport and healthy life-styles, many 
people may find it more than a little incongruous that the organisers of a sporting 
event should not only accept sponsorship from a cigarette manufacturer but that 
they should also ban an entry sponsored by a manufacturer of products which are 
explicitly designed to help people give up smoking (The Times, September 14 1995; 

The widespread sponsorship of sporting events by tobacco companies would not, at 
least in the context of the present argument, be of any significance were it not for the 
fact that, by the early 1980s, cigarette smoking was estimated to be responsible for 
more than 300,000 premature deaths a year in the United States, and nearly half a 
million deaths a year in Europe. In a 1982 report, the US Surgeon-General described 
cigarette smoking as "the chief, single, avoidable cause of death in our society, and 
the most important public health issue of our time", whilst in Britain the Royal 
College of Physicians, in their report Smoking and Health Now, referred to the annual 
death rate caused by cigarette smoking as "the present holocaust" (Taylor, 1985:xiv, 
xvii). Without labouring the point, one might reasonably suggest that the ideology 
which associates sports with healthy life-styles sits uneasily with the widespread 
acceptance of sports sponsorship by breweries and, even more so, by tobacco 
companies.

Exercise and Health

There is now a substantial body of data from both epidemiological and clinical 
studies which indicates that moderate, rhythmic and regular exercise has a 
significant and beneficial impact on health. In Britain, the Coronary Prevention 
Group (1987) has listed the following range of beneficial effects on health:

- Improved cardiovascular function, which is associated with reduced cardiac 
morbidity and mortality
- Increased metabolic rate with advantages from a nutritional viewpoint
- Better control of obesity
- An increase in the HDL/LDL ratio (HDL - High-Density Lipoprotein - is the 
  'good' type of cholesterol; LDL - Low-Density Lipoprotein - is the 'bad' type 
  of cholesterol)
- Decreased blood pressure
- Delayed onset of post-menopausal osteoporosis
- Improved glucose tolerance in diabetes
- Antidepressant, and possible anti-anxiety effects, which may be associated with an increase in the brain of levels of endorphins - substances whose effects are broadly those of an intrinsic heroin-like substance.

The Royal College of Physicians of London (1991:28) has recently echoed these views, arguing that:

There is substantial evidence that regular aerobic exercise such as walking, jogging, dancing or swimming is beneficial to general physical and psychological health. Regular exercise appears to be particularly effective in prevention of coronary disease and osteoporosis and of some value in the management of obesity and diabetes.

Studies in North America point to similar conclusions, and suggest that regular exercise is associated with reduced mortality from all causes, from cardiovascular disease and from cancer of combined sites (Paffenbarger et al, 1986; Blair et al, 1989) while a review of four population surveys (two carried out in Canada and two in the United States), suggests a positive association between physical activity and lower levels of anxiety and depression (Stephens, 1988).

It should be noted that some of these health benefits are very substantial. The British Medical Association, for example, has noted that insurance statistics indicate that men with only moderately high blood pressure can expect to live about 15 years less than men with low blood pressure, and it noted that regular exercise "is potentially a major non-pharmacological method of lowering blood pressure" (BMA, 1992: 18).

Similarly, one of the studies in the United States (Paffenberger et al, 1986) indicates that death rates among men whose work or leisure involves regular exercise are between one-third and one-half lower than those among men whose lives are more sedentary. There are, moreover, three items of good news for those who would seek to improve their health via regular exercise. Firstly, the evidence indicates that the protective effect of exercise persists at all ages, and after other risk factors such as smoking and weight are taken into account; secondly, these benefits can be produced relatively quickly - in just a three month period - in both men and women of all ages, though it should be noted that they are only maintained while the activity is maintained; and thirdly, the beneficial effects are more striking in those who are least active (that is, elderly people or those with chronic disease) (The Nation's Health, 1988: 126-8).

At first glance, studies like those cited above might seem to indicate that the health based arguments in favour of sport are overwhelming. There are however important provisos to be borne in mind when considering studies on the relationship between exercise and health. The first of these is that these studies do not suggest that all exercise is beneficial; rather, they indicate that exercise of a particular kind, amount and intensity has a beneficial impact on health. The Nation's Health (1988: 126) for example, refers quite specifically to the beneficial effects of what it calls "moderate, rhythmic and regular exercise", which it goes on to define as exercise such as that involved in brisk walking, running or swimming for 20-30
minutes about three times each week. The British Medical Association (1992:14) similarly suggested that the "recommended amount of exercise from a health perspective is about twenty to thirty minutes of moderate exercise three times a week". It noted that the exercise that is most frequently suggested is brisk walking, and added that the level of activity which produces significant health benefits "is related to the initial level of fitness: for the middle-aged sedentary individual, this may correspond to walking, cycling slowly or gentle swimming" (1992:14). The precise activity which is considered to constitute "adequate" exercise varies from one study to another, but activities mentioned in this context include "energetic getting about" and manual work around the house and garden (Morris et al, 1980), dancing (BMA, 1992) and regular climbing of stairs (Paffenbarger et al, 1986). It is important to emphasise therefore, that what these studies have documented is a beneficial effect on health of "moderate", or even gentle, forms of exercise; as Morris et al noted, the activities which were defined in their study as constituting adequate exercise were "by no means extreme", and they added, of the 17,944 men who took part in their study, that "our men are no athletes" (1980:1210). The British Medical Association similarly noted that several studies, and "particularly those from North America, have suggested that only rather low levels of activity are necessary to confer some degree of protection against heart disease both in terms of the intensity of effort and of the total amount of exercise taken" (BMA, 1992:19).

This is an important point to note for, quite clearly, one cannot assume that the health benefits associated with moderate exercise will simply be duplicated - still less can one assume that they will be increased - by exercise which is more frequent, of longer duration and of greater intensity, for exercise of this kind, as we shall see later, may generate substantial health "costs" in terms of additional stresses or injuries, for example those associated with "overuse". In short, to suggest that a thirty minute gentle swim three times a week is good for one's health does not mean that running 70 miles a week as a means of preparing for running marathons is good for one's health in an equally simple or unproblematic way. Indeed, it might be noted that one of the American studies, which found that death rates generally went down as levels of physical activity increased, also found a reversed trend at the highest levels of physical activity. The authors note that this result may have been associated with methodological difficulties in the study, though they also recognise that it may reflect "actual increased hazards associated with vigorous activities" (Paffenbarger et al, 1986:606). It might also be noted that one study in New Zealand (Sullivan et al, 1994) - significantly it was a study of competitive athletes, many of whom were ranked in the top 10% nationally in their age group and might therefore be expected to have engaged in relatively intensive training - found a strong positive association between exercise and a large number of symptoms, including anxiety related to competition, stitches, lightheadedness, muscle cramps, wheezing, chest pressure, "spots in front of eyes", retching and incontinence of urine and stool, while it was negatively associated with only a few symptoms, including headaches, abdominal bloating, sneezing and depression.

The second proviso concerning the studies cited above is that most relate primarily to exercise or activity levels rather than specifically to sport. Although sport and exercise are overlapping categories, there are nevertheless important differences between them, and these differences have important implications for their health consequences. It is to these issues that we now turn.
Exercise and sport

Most sociological definitions of sport include the element of physical exertion as an essential component. (Edwards, 1973; Guttman, 1978; Macpherson, Curtis and Loy, 1989). However, if all sport necessarily involves physical exercise, it is not the case that all physical exercise involves sport, for what is usually considered a further necessary component of sport - the competitive element - is frequently more or less absent from many forms of physical exercise. Moreover, since sport is inherently competitive, it must involve more than one person, for while one can exercise alone, one cannot play sport alone, since one needs an opponent. This relatively obvious difference between sport and exercise has important implications for their potentially very different health consequences.

As we have seen, most of the studies cited earlier were concerned with the health consequences of "moderate, rhythmic and regular" exercise. One important difference between sport and exercise is that non-competitive exercise involves a rather different pattern of social relations than does sport and, associated with this, the former is much more likely than is the latter to involve physical movements of a rhythmic nature and, of critical importance, the intensity of the exercise is likely to be, to a much higher degree than in the case of sport, under the control of the individual participant. Consider, for example, the situation of a person who regularly takes a brisk walk, or goes jogging or swimming, as a means of "keeping fit", or perhaps as a means of weight control. When such activities are undertaken alone, as they frequently are, the precise nature of the physical movement - that is the action of walking, jogging or swimming - as well as both the duration and the intensity of the exercise, are to a high degree under the control of the individual involved in the exercise. Thus, for example, a person jogging or swimming alone can determine for how long to continue the exercise, and at what pace. Where exercise of this kind is undertaken in a small group of perhaps two or three friends, as is also common, the duration and intensity of the exercise are likely to involve a level of activity agreed upon by all participants and with which all participants are reasonably comfortable. It is important to note that this is not the situation in the case of sport.

As we noted earlier, sport cannot be played alone for it must involve two or more opposing players. This, together with the fact that sport involves not only cooperation but also, and in a highly institutionalised form, competition, means that sport, and particularly team sport, is usually a considerably more complex social activity than is non-competitive exercise. Consider, for example, a game of soccer or rugby or American football. The game involves a complex interweaving of the actions of a substantial number of players, together with the relationships between players and match officials, club coaches and many others including, at the elite level, large numbers of fans. Even if we considerably oversimplify the situation by confining our analysis simply to the interactions between the players, it is clear that we are dealing here with a social phenomenon of some complexity. Elias and Dunning (1986:193) drew upon the example of Association Football (soccer) to illustrate what they called the "dynamics of sport groups". They wrote:

From the starting position evolves a fluid figuration formed by both teams. Within it, all individuals are, and remain throughout, more or
less interdependent; they move and regroup themselves in response to each other. This may help to explain why we refer to this type of game as a specific form of group dynamics. For this moving and regrouping of interdependent players in response to each other is the game.

It may not be immediately clear that by using the term 'group dynamics' in this context we do not refer to the changing figurations of the two groups of players as if they could be considered in separation, as if each had dynamics of its own. That is not the case. In a game of football, the figuration of players on the one side and that of players on the other side, are interdependent and inseparable. They form in fact a single figuration. If one speaks of a sport-game as a specific form of group dynamics, one refers to the overall change in the figuration of the players of both sides together.

One aspect of the complex structure of sports such as football is that each match tends to develop what is often called a "game pattern". Though there is sometimes a tendency to speak of this game pattern as though it were something separate from the players, it is important to remind ourselves that it is in fact nothing other than the complex interweaving of the actions of a large number of players. However, it is also important to note that, as the game pattern becomes more complex - for example as we move from a two-person game such as tennis to a multi-person game such as soccer - it becomes increasingly beyond the ability of any single player to control this game pattern and, indeed, from the perspective of any single player, this game pattern may appear to have a life of its own.

An associated aspect of the complex structure of many sports is that, in comparison with non-competitive exercise, any individual player is much less able to control his/her own movements and the pace and intensity at which he or she is required to play. Thus while the lone jogger and walker can determine their own movements with minimal reference to others, the movements of, for example, a soccer or rugby or ice-hockey player can only be understood in relation to the movements of other players on their own and the opposition side. Moreover, as a means of beating opposing players, players frequently initiate moves, or respond to the moves of others, involving rapid changes of pace and direction. In most sports, this gives rise to a pattern of movement which is the very opposite of rhythmic, for it often involves sharp and intensive bursts of anaerobic activity, interspersed with short periods in which individual players may be able to take a "breather". It is important to emphasise, firstly, that the frequency and intensity of these bursts of anaerobic activity are, at least in complex games, largely beyond the ability of any single player to control; secondly, that players are almost inevitably constrained by the moves of their opponents to engage in activities which are anything but rhythmic; and thirdly, that many of these movements, such as those involved in rapid acceleration and deceleration, or the twisting or turning movements involved in rapid changes of direction, impose considerably greater stresses on the body than do the much more rhythmic movements involved in non-competitive walking, jogging or swimming. These considerations, however, do not exhaust the health-related differences between sport and exercise. The competitive character of sport, in particular, requires further elaboration.
Sport and competition

Dunning (1986a) has pointed out that the growing competitiveness of modern sport is a long-term trend which may be traced back over two or more centuries. This process has, however, been particularly marked in the post-1945 period, and has been associated with, amongst other processes, the increasing politicization and commercialisation of sport, both of which have had the effect of greatly increasing the importance of, and the rewards associated with, winning while downgrading the traditional value associated with taking part (Waddington and Murphy, 1992). This trend towards the growing competitiveness of sport has not, however, been without health "costs" for athletes, most particularly in the form of more stress injuries and overuse injuries, and increased constraints to continue competing while injured.

A common sight in many sports is that of the trainer or physiotherapist running on to the field of play to treat an injured player, often by the application of an aerosol spray to a painful area, thereby enabling the player to continue. However, as Donohoe and Johnson (1986:94) have pointed out, one of the functions of pain is to "warn' us that we need to rest the damaged area", and they suggest that most athletes and coaches "fail to recognize the damage that can be caused by suppressing pain". This issue is part of the more general concern about overuse and recurrent injuries, a growing problem which is clearly associated with the increasing constraints on sportsmen and women to compete and more particularly to win with, one suspects, often scant concern for the potential longer-term health risks. Donohoe and Johnson (1986:93) have noted that "To succeed in modern sport, athletes are forced to train longer, harder, and earlier in life. They may be rewarded by faster times, better performances and increased fitness, but there is a price to pay for such intense training". Part of the price of such intense training and of the readiness - often encouraged by coaches and medical advisers - to continue training and competing despite injury, is unquestionably paid in the form of overuse and recurrent injuries, which now constitute a serious problem in sport, and not just at the adult elite level.

As Donohoe and Johnson (1986:93) have noted, the "long-term effects of overuse injuries are not known, but some concerned doctors have asked whether today's gold medallists could be crippled by arthritis by the age of 30" and they cite world class competitors who have, in their words, "been plagued by a succession of overuse injuries". Examples of athletes who have continued to compete with painful and potentially serious injuries are almost innumerable. In her autobiography, Olga Korbut, the former Olympic gold medal-winning gymnast, described how, following the 1972 Munich Olympics, the successful Soviet gymnastics team was taken on a tour of what was then West Germany. She wrote:

During that tour of Germany, the lumbago in my back began to hurt more and more. The novocaine injections took away the pain for a while, but I needed time to rest and heal. By the end of the tour, I walked as though I had a stake in my spine....

She added that "My strongest memories of that entire period are fatigue, pain, and the empty feeling of being a fly whose blood has been sucked out by a predatory spider" (Korbut, 1992:81-2).

It would be very wrong to imagine that such incidents only occurred under the now defunct communist systems of Eastern Europe, for examples of athletes playing on
Despite painful and potentially serious injuries are commonplace and there is considerable evidence to suggest that, particularly at the elite level, there are considerable constraints on players to play through pain and injury "for the good of the team". Consider, for example, the following extract from a pre-match team talk to England's top Rugby League team, Wigan, by their coach, John Monie, as reported by Neil Hanson (1991:77):

There's just one more thing I want to enforce. It doesn't matter what's wrong with you when you're injured, I want you on your feet and in the defensive line .... I don't care if the physio's out there and he wants to examine you and all that stuff. That's not important. What's important is .... you've got twelve team-mates tackling their guts out, defending like anything inside the 22 and we've got the physio telling a guy to see if he can straighten his knee out.

I don't care what's wrong with you....if the opposition's got the ball, I want you on your feet and in the defensive line ....

There are no exceptions to that rule. So from now on, the only reason you stay down hurt and get attention from the sideline is because there's a break in play or you're unconscious - no other reasons will be accepted.

Monie's team talk may perhaps be regarded as the English equivalent of the American view that "you play unless the bone sticks through the meat" which, as Young (1993:382) has noted, has long been used to rationalize injury in the NFL. Although it may not always be expressed in such blunt terms, it is clear that, particularly at the elite level, there is a common expectation - which is shared by many players - that whenever possible, players should continue to play through injury "for the good of the team", even if this means playing with pain-killing injections. Hanson reported, for example, that Wigan Rugby League players frequently played after having been given painkilling injections; before the Rugby League Cup Final at Wembley in 1990, so many players had painkilling injections that the club doctor, Dr Zaman, came into the dressing room "clutching a collection of used syringes and needles" and asked of a Wembley official, "Do you have a box for sharps?" (Hanson,1991:193). Don Strock, former quarterback with the Miami Dolphins, has described how players would group around "injured teammates during a game to screen from spectators the use of pain-killing injections, then hide the needles under the carpet-like synthetic 'turf' " (cited in Young, 1993:376). The Russian international soccer player Andrei Kanchelskis, who is currently playing in England, was recently reported to have played in an international match for Russia after having no fewer than eight painkilling injections for a stomach strain (The Guardian, 3 April, 1995) while the former England soccer captain, Gary Lineker, who recently retired after a long struggle with a chronic foot injury, indicated that he had been concerned about continually using painkilling drugs. He was reported as saying of his retirement: "It is as if a huge weight has been lifted from me. I no longer have to worry whether I'll be fit enough to get through a match and I will no longer have to suffer the dizzy spells and stomach complaints that come with a dependency on anti-inflammatory drugs" (Daily Mirror, 21 November, 1994).

It is clear that experiences of this kind are commonplace among elite players; in
England a recent survey of 725 professional soccer players carried out by the magazine *Four Four Two* (October, 1995) revealed that seventy per cent of players had been asked to play when not fully fit. As Young *et al* (1994:190) have noted;

Overt and covert pressures are brought to bear on injured athletes to coerce them to return to action. These may include certain "degradation ceremonies".... such as segregated meal areas, constant questioning from coaches, being ostracized at team functions, or other special treatment that clearly identifies the injured athlete as separate.

An example of this kind of ostracism concerns the former Liverpool Football Club manager, Bill Shankly, regarded by many as one of the greatest-ever soccer club managers; Shankly refused to speak to any player who was unavailable to play because of injury (*On the Line*, 1996). Young *et al* (1994:190) have argued that:

Pressure placed on the player to return to action before full recovery is in one sense intended to enhance the team's ability to win, but in the process, the long-term health of the athlete is often given little consideration.

Although such pressures on players to tolerate and to play through pain may in some respects be associated with particular conceptions of masculinity - to be examined later - it is also clear that there are broadly similar constraints on women athletes to continue competing despite pain and injury and that many women athletes respond in a broadly similar way to their male counterparts. For example, in comparing their research in Canada on female athletes' experience of pain and injury with their earlier research on the experience of male athletes, Young and White (1995:51) write that "If there is a difference between the way male and female athletes in our projects appear to understand pain and injury, it is only a matter of degree....it is clear that both men and women adopt similar techniques to help to displace the centrality of pain in their sports lives". An example of the way in which pain is denied is provided by the example of "D", one of the elite women athletes interviewed by Young and White (1995;51):

The first time my injury occurred, I ignored it assuming it would go away, as did my previous aches and pains. Bruising, swelling, and muscle pain are integral aspects of basketball. Once the pain persisted, it became annoying. It never occurred to me at the age of 14 that my body was breaking down and needed a rest. I simply pushed harder because my injury was causing me to fall behind in my progress.

Young and White (1995:52) add that:

Years of denial and persistence have seriously weakened D's knees and ankles, and surgery to repair cartilage tears has left her legs badly scarred. At the time of writing, D remains in pain, is unable to play her sport, and uses painkillers almost daily.

D's reference to injuries during her teenage years suggests that the problem of overuse and recurrent injuries is not confined to adults. In relation to children's sport, Donnelly (1993:96) has noted that:
As children encounter opportunities for increasingly lucrative careers as professional athletes, parents are tempted to encourage their children to become heavily involved in professional sports at early ages. As evidenced by increasing demands for international success in sport as a justification for government and corporate spending on elite participation, and by a variety of attempts to establish schemes for the early identification of athletic talent, there is an obvious trend toward earlier and more intensive athletic involvement for younger and younger children.

Donnelly notes that injuries characteristic of overtraining among young athletes have been widely reported in the literature (eg Rowley, 1986), and that such injuries were also reported by a majority of the 45 recently retired high-level athletes who were interviewed in Donnelly's study and who spoke about their own experiences as young athletes.

Given the highly competitive characteristic of much modern sport, it should come as no surprise to learn that overuse and recurrent injuries are very common. Thus Lynch and Carcasona (1994) have noted that a study of 123 male players in a Danish soccer club found that 37% of all injuries were overuse injuries, while a Swedish study of 180 senior male soccer players found that 31% of injuries were due to overuse. FIFA's report on soccer's 1994 World Cup, held in the United States, indicated that 12% of all treatments of players were for chronic injuries or ailments which predated the World Cup Finals (Nepfer, 1994:190). It would however be quite wrong to think that such injuries only occur at the elite level, for there is little doubt that in most western countries sport at all levels has become increasingly competitive and this has given rise to large numbers of recurrent injuries at the non-elite, as well as the elite level. A large-scale survey recently carried out in England and Wales for the Sports Council found that one-third of all injuries resulting from participation in sport or exercise were recurrent injuries. On the basis of this study, the Sports Council estimated that in England and Wales there are 10.4 million incidents a year resulting in recurrent injuries (Sports Council, 1991:25). Quite clearly, we are not dealing with a phenomenon which is confined to elite sport, but one which is extremely widespread.

Sport, violence and aggressive masculinity

Many sports, unlike most forms of non-sporting exercise, involve physical contact and are, in effect, mock battles. This is perhaps most evident in the case of combat sports, in some of which - for example, boxing - a central object is to inflict physical damage on one's opponent. Clearly, however, the use of violence is not confined to combat sports, for though the level of physical violence permitted in sport has, in general, shown a long-term decline as sports have become more "civilized" (Dunning and Sheard, 1979; Dunning, 1990), the use of physical violence to a greater or lesser degree remains a central characteristic of modern sport. In this regard, Dunning (1986b: 270) has noted that:

All sports are inherently competitive and hence conducive to the arousal of aggression. Under specific conditions, such aggression can spill over into forms of open violence that are contrary to the rules. In some sports, however - rugby, soccer, hockey and boxing
are examples - violence in the form of a "play-fight" or "mock battle" between two individuals or groups is a central and legitimate ingredient.

Many sports have, in present-day societies, become enclaves for the expression of physical violence, not in the form of unlicensed or uncontrolled violence, but in the form of socially sanctioned violence as expressed in violently aggressive "body contact"; indeed, in the relatively highly pacified societies of the modern West, sport is probably the main - for many people the only - activity in which they are regularly involved in aggressive physical contact with others.

The link between sport, aggression and violence provides an important key to understanding why sport is a major context for the inculation and expression of gender differences and identities, for sport constitutes perhaps the most widely available arena for the legitimate expression of masculine aggression and for the display of traditional and dominant notions of masculinity involving physical strength and courage. Thus, Young et al (1994:176), drawing upon their interview data with Canadian adult male athletes, have noted that the use of force and violence and the tolerance of risks, pain and injury are valued by many male athletes as masculinizing, while the sporting performances of women, gay men and men pursuing alternative versions of masculinity are, by contrast, trivialized. In similar fashion, Sheard and Dunning (1973), in their essay on the rugby club as a type of "male preserve", have noted that many of the songs traditionally sung in rugby clubs stress and reinforce masculinity by mocking, not only women but also gay men.

Young et al (1994) have pointed out that these traditional and dominant concepts of masculinity involve, as a central proposition, the idea that "real" men play sport in an intensely confrontational manner. In the more violent contact sports, this may mean that bodies are used as weapons for, as Messner (1990:203) has noted:

In many of our most popular sports, the achievement of goals (scoring and winning) is predicated on the successful utilization of violence - that is, these are activities in which the human body is routinely turned into a weapon to be used against other bodies, resulting in pain, serious injury, and even death.

In such a context, players are expected to give and to take hard knocks, to injure and to be injured and, when injured, to "take it like a man". A prime example is provided by American football which, though considerably less violent than it was in the late nineteenth century, remains, by comparison with most sports, relatively violent; it is significant that proponents of American football list among what they see as the positive features of the game its bellicosity and its similarities to actual warfare and the pain and self-sacrifice which it requires, whilst injury becomes what Guttman (1978:121) has called "a certificate of virility, a badge of courage". For many players and fans alike, relatively violent sports such as American football and rugby are, precisely because of their violent character, arenas par excellence for young men to demonstrate their masculinity. Not surprisingly, injury rates associated with such sports are considerably higher than those associated with most other sports and very much in excess of those associated with non-competitive exercise. In relation to American football, for example, Guttmann (1988:161-2) has pointed out that:

The percentage of players incurring injuries severe enough to cause them to miss at least one game a season is over 100 percent; this
means not that every NFL player is injured at least once each season, but that those who are not injured are more than offset by those who are injured several times. The average length of a playing career has dropped to 3.2 years, which is not long enough to qualify a player for inclusion in the league's pension plan.

Studies from England (Sports Council, 1991) and New Zealand (Hume and Marshall, 1994) similarly indicate that injury rates in rugby are substantially above those in any other sport.

The epidemiology of sports injuries

Sports injuries are extremely common and, quite clearly, the risk of injury has to be taken into account in any attempt to assess the health "costs" and "benefits" of sport and exercise. In this context, a large-scale study carried out for the Sports Council in England and Wales (1991) provides a great deal of relevant information and is worth examining in some detail.

A postal questionnaire, which asked about participation in sports and exercise and injury experiences in the previous four weeks, was sent to a sample of 28,857 people, selected at random from the lists of family (primary care) physicians. The response rate was 68%. Of the 17,564 usable responses, 7,829 respondents (45%) had taken part in vigorous exercise or sport; 1,429 had been injured, and they reported a total of 1,803 injuries (1991: 2).

The number of injury incidents was weighted and multiplied to provide estimates of the annual incidence of sports injuries in England and Wales. On this basis, it was estimated that there were 19.3 million incidents resulting in new injuries and a further 10.4 million incidents resulting in recurrent injuries, making a total of no fewer than 29.7 million injuries a year. The direct treatment costs of new and recurrent injuries were estimated at £422 million, with costs of lost production (due to days off work) estimated at £575 million, giving a total annual cost of sporting injuries of £997 million (1991: 25, 31). In the light of these data, one can understand why one text on sports injuries (Vinger and Hoerner, 1982) is sub-titled "The Unwharton Epidemic".

As was noted earlier, injury risks vary markedly from one sport to another with, not surprisingly, the highest risks being associated with contact sports. The Sports Council study (1991:33) found, for example, that rugby was by far the most dangerous sport, in terms of risk of injury, with an injury rate of 59.3 per 100 participants per four weeks. The second most dangerous sport was soccer (39.3) followed by martial arts (36.3), hockey (24.8) and cricket (20.2). A recent study in New Zealand (Hume and Marshall, 1994) similarly found that rugby union had the highest injury rate, while other high-risk sports included horse riding, soccer, cricket, netball, rugby league, basketball and snow skiing. That there is a close association between physical contact and injury risk is clear; Lynch and Carcasona (1994: 170-1) cite a study of youth outdoor and indoor soccer in the United States which found that 66% of injuries in the outdoor league and 70% of injuries in the indoor league resulted from physical contact.

Not surprisingly, the Sports Council study in England and Wales found that the activities with the lowest risks of injury were the non-contact and rhythmic (and
largely non-competitive) activities involved in "keep fit" (6.5 incidents per 100 participants per 4 weeks) and swimming and diving (2.9). However, even relatively rhythmic and non-contact activities may be associated with substantial injury risks; Heil (1993:5) notes that it has been estimated that in the United States, a third of the nation's 15 million joggers sustain a musculoskeletal injury each year and nearly a half of habitual runners experience lower extremity injury, while there are also one thousand spinal injuries each year as a result of swimmers diving into water.

Although the majority of sporting injuries are relatively minor, a substantial number are more serious. The Sports Council study (1991:18-19) found that 25% of new injuries and 31% of recurrent injuries required treatment by a family doctor, hospital or other health professional, while 37% of new injuries and 43% of recurrent injuries involved some restriction on activities. This restriction was usually on the injured taking part in sports or exercise, though 7% of all injuries resulted in the participants taking time off work; in all 11.5 million working days a year are lost in England and Wales as a result of sports injuries. A study in New Zealand (Hume and Marshall, 1994) found that 15% of consultations at the Dunedin Hospital Emergency Department were for sports injuries, which also accounted for 9% of all injury hospitalisations in New Zealand, and 17% of all injuries compensated by the Accident Compensation Corporation. Both the risk of injury, and also the risk of serious injury, increase in more violent contact sports. Thus Young (1993:377), writing of American football, has argued that:

No workplace matches football for either the regularity or severity of injury....football injuries may include arthritis, concussion, fractures, and, most catastrophically, blindness, paralysis and even death....a review of heat stresses such as cramp, exhaustion and stroke related to amateur and professional football .... reported 29 player deaths between 1968 and 1978....the 1990 season represented the first in over 60 years without a player death.

Conclusion

What conclusions, then, can we draw about the relationships between exercise, sport and health? Three points would seem to emerge from the data reviewed in this paper. The first is that no simple generalisation can adequately encapsulate the complexity of these relationships. The second, related, point is that it is clearly necessary to differentiate between exercise and sport for they involve, as we have seen, rather different patterns of social relationships and, associated with this, they are likely to have rather different consequences for health. The third point is that we also need to differentiate between types and levels of sport, with the distinctions between contact and non-contact sport and between elite and mass sport being particularly important.

If we make these distinctions, it may be possible to reconcile what, at first sight, may appear to be radically incompatible findings. Thus, on the one hand, there does seem to be overwhelming evidence indicating that regular, rhythmic and moderate exercise has a significant and beneficial impact on health. On the other hand, Young (1993:373) may also be correct in his claim, which appears to relate primarily to North America, that:
By any measure, professional sport is a violent and hazardous workplace, replete with its own unique forms of "industrial disease". No other single milieu, including the risky and labor-intensive settings of miners, oil drillers, or construction site workers, can compare with the routine injuries of team sports such as football, ice-hockey, soccer, rugby and the like.

In general, it is probably reasonable to suggest that in the case of rhythmic, non-competitive exercise where body movements are, to a relatively high degree, under the control of the individual participant, the health benefits substantially outweigh the health costs. However, as we move from non-competitive exercise to competitive sport, and as we move from non-contact to contact sport, so the health costs, in the form of injuries, begin to mount. Similarly, as we move from mass sport to elite sport, the constraints to train longer and more intensively and to continue competing through pain and injury also increase, with a concomitant increase in the health risks. The health-related arguments in favour of regular and moderate exercise may be overwhelming, but such arguments are rather less persuasive in relation to sport in general, and very much less persuasive in relation to elite, or professional, sport.

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Summary of Published Work: Themes and Perspectives.

The published work submitted as the basis of this application for the award of the degree of Ph.D. has one obvious underlying theme, for all the work is concerned with aspects of the sociology of health and medicine. Though the central thrust of this work is concerned with what might be called the historical sociology of medicine, a number of other issues within the sociology of medicine are also dealt with, ranging from contemporary policy issues such as social class inequalities in health care, health care in developing societies and the problems of managing change within the NHS, to the development of sports medicine and the use by athletes of performance-enhancing drugs.

However, beyond this obvious concern with health and medicine there are other, more theoretical, continuities. The publications submitted were written over a period of some twenty-three years and it would be surprising - and perhaps indicative of a lack of sociological development - if there were not some differences in emphasis between the earlier and the later works, and it is certainly the case that these theoretical concerns are sometimes more implicit and at other times more explicit in these works. Nevertheless, it can be said that throughout this period my work has been guided by some underlying concerns which have served, to borrow Marx's famous phrase, as "a guiding thread for my studies" (Marx, 1962:362). The primary object of this summary is to highlight these theoretical continuities. In particular, I wish to emphasise: (i) a continuing concern with historical, or developmental, sociology; (ii) the always present but steadily growing influence of the work of Norbert Elias and; (iii) a continuing commitment to the role of the sociologist as what Elias (1978a:50-70) called "a destroyer of myths".

Historical sociology.

One of the central concerns in my work has been with what is often called historical sociology. As a young Leicester postgraduate student, I attended Norbert Elias's seminars in theoretical sociology, and was greatly influenced by Elias's approach to what many people called historical sociology but what Elias then called developmental sociology (it was not until some years later that his approach came to be known as figural or process sociology). I was also considerably influenced by EH Carr's seminal work *What is History?* (1961), in which Carr argued persuasively for a *rapprochement* between history and sociology. In the light of the growing influence over the years of an Eliasian perspective in my work, it is interesting to note - though I was not aware of this at the time - that Carr had privately discussed with Elias many of the problems dealt with in his book, while Elias himself subsequently drew attention to some important similarities between his own ideas and those contained in *What is History?* (Elias and Scotson, 1965:169).

As a young researcher, I was persuaded by Carr's argument that the clear-cut disciplinary boundaries which many people sought to maintain between history and sociology were not only difficult to sustain intellectually but that
they were also unhelpful to both disciplines for - notwithstanding the work of writers such as Carr - the relationship between history and sociology was often presented in terms of a rigid division, sometimes involving mutually hostile stereotyping by historians and sociologists, which hindered the development of both disciplines. The consequences of this unhelpful division of labour were particularly conspicuous in the history and sociology of medicine, in part because the problems associated with inter-disciplinary relationships were exacerbated by the fact that at that time medical history was somewhat marginal to mainstream history while medical sociology was, in a similar fashion, somewhat marginal to mainstream sociology. Let me elaborate by describing, necessarily in rather broad terms, the general character of medical history and medical sociology at the time that I began my own research.

Writing in 1971 - just two years before my first paper was published - the distinguished medical historian Charles E Rosenberg not inaccurately suggested that most historical studies of the physician tended towards "the episodic and anecdotal, emphasizing the atypical, even the quaint and quack at the expense of systematic consideration of patient care". He went on to suggest that the "majority of institutional studies, moreover, tend to be construed in the narrowest of internal terms; histories of hospitals, of associations, of societies based on a one-dimensional narrative of overt incident supplemented by arbitrary biographical compilation" (Rosenberg, 1971:22-35). It would not be correct, of course, to suggest that the work of all medical historians was characterised by the deficiencies identified by Rosenberg - Rosenberg's own work was one notable exception - though he undoubtedly identified some major shortcomings of mainstream medical historical writing.

Some of these criticisms were perhaps also applicable, to varying degrees, to other areas of historical writing - particularly, Rosenberg suggested, to the writing of intellectual history - but they were especially relevant to medical history at that time. This was, perhaps, not surprising, for much of the literature of medical history was then being written by people who had no training in either history or sociology, for many writers in this field were medical practitioners who had taken up medical history as a spare time interest, or perhaps to occupy their time after retirement. Much of the literature thus tended to lack both the conventional scholarship traditionally characteristic of the academic historian and the theoretical sophistication of the sociologist. This in part explains the empiricism, the inability to separate the important from the trivial and even the antiquarianism which, as Rosenberg noted, characterised much medical historical writing at that time.

A further characteristic of much medical historical writing during this period was the tendency of many historians to offer "explanations" of social phenomena, such as the development of medical knowledge or of professional organisations, in terms of the personal characteristics of one or two outstanding individuals. Clear examples of this personality-centric approach can be found in the work of several eminent medical historians.
whose work was influential in the 1960s and 1970s. Thus in comparing the early development of the British Medical Association with that of other medical societies, WH McMenemy, the biographer of the founder of the BMA, Sir Charles Hastings, argued that: "In the last resort it is the character of the leader of an organisation which counts. He may no longer be alive but his spirit will pervade the meetings, and the standards will be those he has set" (McMenemy, 1961:79). A similarly individualistic approach to the explanation of social processes can be seen in Noel Poynter's comment, in relation to the development of the sanitary movement in the nineteenth century, that "if we search into the intellectual origins of this movement we find that it began with a change of religious belief by a man who became the eloquent evangelist of sanitary reform", namely Southwood Smith (Poynter, 1973:50).

One consequence of this approach - and it should be borne in mind that the above comments come from two of the most prominent medical historians of the period - was the tendency on the part of many medical historians to document in some detail the personal virtues and vices of particular individuals which, either explicitly or implicitly, were used as explanatory variables. Thus, for example, Charles Newman, whose *The Evolution of Medical Education in the Nineteenth Century* (1957) was a standard text, argued that Thomas Wakley, the founding editor of *The Lancet*, was the "driving force" behind the medical reform movement of the early nineteenth century. Wakley was, we were told, "a lifelong agitator", an "ill-intentioned fellow....and a perfect nuisance". His trouble, suggested Newman, "was probably the internal contradictions in his make-up" (Newman, 1957:140-41). Even if we leave aside the lack of detachment which these comments reveal it is clear that, whether or not such detailed descriptions are accurate, their explanatory power is, at best, extremely limited. As I sought to demonstrate in some of my early papers (Waddington, 1973a; 1977a; 1979), the development of the medical reform movement can only be adequately understood via a systematic analysis of the tensions and conflicts within the medical profession, and not in terms of the actions or personality of a single individual.

Underpinning my work in this area was the fundamental principle that the resort to individual characteristics in order to "explain" social processes is a resort of theoretical bankruptcy. As Elias pointed out in a rather different context, "specific maladjustments, discrepancies of one kind or the other between professional institutions and the needs they serve, and tensions between groups of people engendered by those discrepancies, impose their pattern upon individuals. They, not individuals as such, are the main levers of a profession's development" (Elias, 1950:292). It has, of course, long been a fundamental axiom of sociology that one cannot explain processes on one level of analysis - the social - by reference to processes on another level, that is in this case, by reference to processes on a personality, or individual, level. That so many eminent medical historians continued to seek explanations of social processes in non-social terms was a major source of the theoretical sterility of much medical historical writing at that time.
It was for this reason that my first three published articles (Waddington, 1973a; 1973b; 1975) all carried the subtitle "A sociological analysis" for, in much the same way that Durkheim used the subtitle "A study in sociology" to indicate that his study of suicide was distinctively different from the more usual psychological studies which preceded it, so I wished to indicate quite clearly that whilst my articles dealt with what might appear to be conventional historical issues, they were not written from a conventional historical perspective but rather, they involved the attempt explicitly to use a sociological perspective to advance our understanding of historical, or developmental, processes.

If historians in general, and medical historians in particular, were making little use of the theoretical and methodological tools of sociology it is equally true that few sociologists at that time showed much inclination to adopt a more historical, or developmental, perspective in their work. It is true that C. Wright Mills had recently referred to history as "the shank of social study" and had suggested that "without use of history....the social scientist cannot adequately state the kinds of problems that ought now to be the orienting points of his (sic) studies" (Mills, 1970:159) and that there were a few others who similarly echoed, from the sociological side of the divide, Carr's call for a *rapprochement* between sociology and history. Nevertheless, Barrington Moore, whose *Social Origins of Dictatorship and Democracy* (1967) was an outstanding but all too rare example of historical sociology, was undoubtedly correct to draw attention to the lack of historical perspective and the static bias in most social science writing (Moore, 1958:111-59). This bias was similarly criticised by Thernstrom (1973), who called it the "parochialism of presentism", a description which finds an echo in Elias's more recent (1987) observations on "the retreat of sociologists into the present".

If a historical perspective was lacking in most sociological work, such a perspective was almost entirely absent from the sociology of medicine at that time. For example Reid (1975-6) pointed out that in the second edition of the register of research in *Medical Sociology in Britain* (Johnson, 1974), only 3 out of the approximately 180 research projects listed took an historical perspective. One possible reason for the ahistorical character of medical sociology lay in the preoccupation of medical sociologists at that time with their respectability vis-à-vis the medical profession, a point to which Atkinson (1974) drew attention in an early edition of the Newsletter of the then recently-formed Medical Sociology Group of the British Sociological Association. This preoccupation was perhaps understandable, given the relative newness and the still somewhat marginal status of medical sociology vis-à-vis both medicine and sociology at that time. One aspect of this status marginality was reflected in the fact that many - perhaps a majority of - medical sociologists were then employed not in sociology departments but in medical schools where they were required continually to justify their work to clinicians who were often hostile to the inclusion of sociology within the medical curriculum; notwithstanding the fact that the Royal Commission on Medical Education (1968) had recently and strongly supported the teaching of sociology to medical students.
A second aspect of the marginal status of medical sociologists was associated with the fact that they were often constrained to justify their research projects to funding bodies which were likely to be more impressed by research with an overtly "applied" character with clinical applications, than by research which aimed to make a more basic contribution to the development of sociology as a discipline; in this connection it is interesting to note that Reid (1975-6), in her analysis of the research listed in the 1974 register of Medical Sociology in Britain, noted that at least half the projects listed were funded by either the Medical Research Council or the Department of Health and Social Security (or its Scottish equivalent), on all of which sociologists had little or no representation. Thus both the employment situation and the structure of funding for research in medical sociology constrained medical sociologists to adopt criteria of relevance drawn up by non-sociologists, that is, by medical practitioners, for most of whom an understanding of the historical or developmental aspects of medicine and health care was a relatively low priority.

Within this context, my own studies had two objectives: (i) to make a contribution towards understanding some specific empirical processes associated with the development of the medical profession, such as the development of medical knowledge (Waddington,1973b), the development of medical ethics (1975), intraprofessional conflict (1973a; 1977a; 1979) and professionalisation processes more generally (1984; 1985a) and; (ii) to make a contribution towards breaking down disciplinary boundaries and encouraging fruitful cross-fertilisation between the historical and the sociological perspectives on medicine, or, as I would now put it, making a contribution towards a properly developmental sociology of medicine.

By the late 1970s, my work, together with that of my Leicester colleagues Sydney Holloway and Nick Jewson, both of whom adopted a broadly similar perspective, was considered sufficiently distinctive to be described collectively as the work of the "Leicester School". Writing in 1977, Woodward and Richards noted both the distinctiveness of our approach and the paucity of other work in this area and concluded that "Except for the publications....from what may be termed the 'Leicester School'...., there has been little work in the historical sociology of medicine" (1977:30), a point which they subsequently reinforced with the observation that the "studies by Holloway, Waddington and Jewson remain almost the sum total of effort in a historical sociology of medicine" (1977:32). It could therefore legitimately be said that the work of the "Leicester School" played a significant part in the early development of the historical sociology of medicine.

It would also be reasonable to claim that my work has generally been well received by colleagues in both the history and the sociology of medicine, a claim which is perhaps at least partially validated by the fact that I was elected to serve on both the Executive Committee of the Society for the Social History of Medicine (1974-77) and on the editorial board of The Sociology of Health and Illness (1980-86). There are, too, other and more direct indications
of the way my work has been received. My book on the medical profession (1984) was recently described by Brazier et al (1993;200) as one of "two standard sources" on the development of the medical profession in Britain (the other work cited being Berlant, 1975), while Cassell has suggested that "the best recent studies" of the changing structure of the medical profession in the nineteenth century, and in particular of the development of the general practitioner-consultant relationship, are those by Loudon (1986) and myself. Shortt, in the course of a review of a book on the medical profession in Canada, noted that: "Over the last dozen years, the evolution of the British and American medical profession has been subjected to scrutiny by a number of scholars", and he singles out for mention the work of Paul Starr and William Rothstein on the American medical profession and of M. Jeanne Peterson and myself on the medical profession in Britain; he goes on to regret the fact that "the historiography of Canadian medicine can claim no such studies" (Shortt, 1986:369). More recently, Cooter has indicated that the argument which Berlant and I separately advanced in 1975 in relation to the development of medical ethics has now become the "established" - he calls it "the now entrenched" - view (Cooter, 1995:265). My work also resulted in the invitation to write the article on the professionalization of medicine for the special 150th anniversary edition of the British Medical Journal (1990), and in the invitation to write the section on "Professions" in the first and second editions of the Social Science Encyclopedia (1985; 1996).

Although an historical or developmental perspective is most clearly evident in my work on the medical profession in the eighteenth and nineteenth centuries, this perspective also informs my analysis of what might be considered more contemporary issues. Thus, for example, in the analysis of drug use in sport (Waddington and Murphy, 1992) and in my analysis of the relationship between sports medicine and the development and use of performance-enhancing drugs (1996), considerable stress is laid upon the importance of understanding fairly long-term changes (ie changes in the twentieth century) in the structure of sporting competition, and in the structure of medical practice in general and sports medicine in particular. These concerns with long term processes of change are also evident in my recent paper with Dopson (1996) in which, despite the fact that we are dealing with what is ostensibly a short term and very practical question - the introduction, following the Griffiths Report of 1983, of general management into the National Health Service - we continually stress the importance of locating these short-term changes within the context of longer-term processes of change.

It is pleasing to note that, over the last two decades, there has been a shift of both medical history and medical sociology along the lines for which I and other members of the "Leicester School" were arguing in the 1970s. In his trend report on the sociology of health, White (1991:3) referred to "a growing awareness among students of medical history that some interface between medicine and history and sociology must be established". I am happy that my own work may have made a modest contribution to this development.
The Eliasian perspective.

The influence of Norbert Elias has always been present in my work, though that influence has grown substantially in recent years. Several of my earliest papers (e.g., 1973a, 1973b, 1977a) made reference to the work of Elias though, at that time, I drew upon Elias’s work in a somewhat ad hoc fashion - for example, to bring out similarities between his study of the naval profession (Elias, 1950) and my own work on the medical profession, or to use his conceptualisation of established-outsider relations (Elias and Scotson, 1965) to illuminate my work on the College of Physicians - and I had only a limited awareness of the more general framework which, I later came to realise, constituted his distinctive approach to sociology. That I then had such a relatively limited awareness is not altogether surprising, for much of Elias’s work, and in particular some key texts which set out the approach which he later called figurational or process sociology, did not become available in English until the late 1970s and early 1980s. Thus the two volumes of Elias’s magnum opus, The Civilizing Process, were not available in English until 1978 and 1982. The Court Society only appeared in English in 1983 while What is Sociology? in which, arguably, Elias sets out most systematically the general principles of figurational sociology, was not available in English until 1978.

It was, then, not until the 1980s that my own work began to be underpinned more systematically by a figurational perspective. Significantly, since the control of violence was one of the central themes of The Civilizing Process, the first signs of this more systematic use of a figurational perspective can be seen in the work on collective violence which I did with Eric Dunning and Patrick Murphy (Dunning, Murphy, Newburn and Waddington, 1987; Dunning, Murphy and Waddington, 1991; 1992) which, since it is not concerned with any aspect of medical sociology, is not included as part of this submission. In relation to my work on medicine, the growing influence of figurational sociology is most clearly seen in my work on drugs and sport (Waddington and Murphy, 1992) and in the recent paper on managing change within the National Health Service (Dopson and Waddington, 1996). It might be noted that the latter paper breaks some new ground, for there has been very little work, from an Eliasian perspective, on processes of organizational change and, as far as I am aware, no work of this kind has previously been done in relation to the NHS.

Though it is not appropriate to examine Elias’s approach in detail here, it may be helpful briefly to identify those aspects of his work which I have found particularly useful. As I indicated previously, I was initially attracted to Elias’s work because of his concern with historical or developmental sociology, that is to say, for broadly the same reasons which made Carr’s work attractive and, as noted earlier, I later discovered that some of Carr’s work had benefitted from his discussions with Elias. However, there is considerably more to figurational sociology than simply a concern with processes of development. In particular, I would highlight the following aspects:
i) Elias was very critical of the tendency among many sociologists towards what he called "process-reduction", that is the tendency to use concepts which reduce social processes to static conditions (Elias, 1978a:111-16). The concept of "figuration", he suggested, offered a means of overcoming the static connotations associated with more conventional concepts such as "structure" and thereby helps us to conceptualise social processes as processes, rather than as a series of movements between static states. In this context, we might note that Rojek (1992:15) has argued that more conventional sociological concepts do not convey "the mobile, unfinished qualities of human relations as unequivocally as the concept of figuration", while Baumann (1979:119) has similarly concluded that figurations "cannot help but being at the same time stable...and dynamic..."; figurations, as a matter of fact, negate and transcend the very opposition between stability and change. Figurationalists would argue that this perspective is relevant to the analysis of all social processes, but it is easy to see why this perspective should appeal, in particular, to those with an interest in long-term processes of development.

ii) Elias was also very critical of what he described as "quite senseless conceptual distinctions, like 'the individual and society', which makes it seem that 'the individual' and 'society' were two separate things, like tables and chairs, or pots and pans" (Elias, 1978a:113). Again, the concept of "figuration", he suggested, can help us to overcome unhelpful dichotomies of this kind. In this context, Baumann (1979:118-9) has pointed out that the concept of figuration is a "two-edged sword", with one edge aimed effectively against individualistic explanations of social processes, and the other edge aimed at reifying concepts such as "social system". Turner (1985:159-60) has made a similar point, noting that the concept of figuration is a means of avoiding both "methodological individualism and the reification of sociological categories by concentrating on the webs of interdependence ('figurations') between people and the power balances which characterise these webs". Again, figurational sociologists would argue that this perspective was relevant to the investigation of all social phenomena, though it has an obvious resonance in some of the debates between sociologists and historians, particularly those relating to such things as the role of the individual in history.

iii) It may be argued that, in his work on involvement and detachment (1956;1987), Elias moves beyond the classical - and, it has to be said, often sterile - debate in sociology about "objectivity versus subjectivity". Moreover, it is important to emphasise that what Elias offers is not another contribution to a philosophical discussion which is often conducted in absolutist terms but, particularly in his analysis of "double-bind processes" (1987:68-74), a genuinely sociological perspective on the development of science, on the changing relationship (both through time and between one society and another) between the observer and that which is observed and, associated with this, on the changing balance between involvement and detachment. The attempt to maintain an appropriate degree of detachment in the search
for more adequate explanations has long been a central part of my own conception of what is involved in the task of doing research.

iv) In *What is Sociology?* (1978), Elias devoted a whole chapter to the role of the sociologist as "a destroyer of myths". He argued that, if we study the development of science:

it is soon discovered that the cause of science has been advanced in certain societies by small groups struggling against untested, prescientific systems of thought. To other and usually far more powerful groups, these latter beliefs appear quite obvious. Scientifically thinking groups are generally groups which criticize or reject the dominant and commonly accepted ideas of their society, even when these are upheld by recognized authorities, for they have found that they do not correspond to the observable facts. *In other words, scientists are destroyers of myths.* By factual observation, they endeavour to replace myths, religious ideas, metaphysical speculations and all unproven images of natural processes with theories - testable, verifiable and correctable by factual observation (Elias, 1978a:52).

The theme of the sociologist as a destroyer of myths is illustrated in relation to my own work in the next section.

**The sociologist as a destroyer of myths.**

A commitment to the role of the sociologist as a destroyer of myths - not for its own sake, but as a necessary corollary of trying to develop more adequate explanations and therefore subjecting professional and other ideologies to critical analysis - has been a continuing theme in my work. A few examples, ranging from some of my earliest to some of my most recent work, will serve to illustrate this aspect of my work:

i) In my early article on medical ethics (1975), I was critical of the view - which was then the dominant view in the sociological literature as well as being an important part of the ideology of most professionals - that the development of professional ethics could best be understood as a means of regulating professional-client relationships in such a way as to prevent the exploitation of potentially vulnerable clients. I attempted to show, via an empirical examination of the development of medical ethics in the nineteenth century, that although some limited aspects of the codes of medical ethics related to doctor-patient relationships, the primary concern of those who drafted those ethical codes was to regulate relationships not between doctors and their patients, but between doctors and their fellow practitioners. In this context, I attempted to show that the changing structure of the profession at that time was associated with a great deal of intraprofessional conflict, competition, rivalry and jealousy and that the primary function of these developing codes of medical ethics was to regulate relationships between practitioners in such a way as to reduce the amount of potentially damaging
intraprofessional conflict. As noted earlier, Cooter has recently described this as "the now entrenched" view of medical ethics, though at the time my argument differed markedly from what was then the established view both in sociology and, not surprisingly, amongst the professions. It is interesting to note that, although Elias's comments on the sociologist as a destroyer of myths were not then available in English (What is Sociology? was not available in English until 1978) I concluded by drawing upon the work of Peter Berger in order to make a point which was not very dissimilar to that made by Elias. I wrote:

It would seem that for too long sociologists have accepted on trust the bland assurances of the professionals themselves that codes of ethics develop purely in order to protect clients. If sociology is, as Berger suggests, the art of mistrust, then it is perhaps time we were a little less trusting (1975:49).

ii) A longstanding part of the ideology of the modern medical profession is that the primary function of medical registration is to protect the public, and this view has also been accepted by many medical historians (Waddington, 1984:137-8). In another of my early papers I offered what I described as a "sceptical analysis of the significance of registration", in which I argued that an important dimension of the campaign for medical registration involved the attempt, by medical practitioners themselves, to gain a greater degree of control over the market for their services, in particular by restricting entry to the profession (Waddington, 1979). I was, of course, not alone in drawing attention to these monopolistic aspects of the professionalization process, for a number of other writers at that time (eg Parry and Parry, 1976; 1977, and most notably Berlant, 1975, whose work revolves almost exclusively around the theme of professionalization as a monopolization strategy) were arguing along similar lines. However, neither the work of the Parrys nor that of Berlant was based on detailed historical analysis of primary materials and their work therefore has what Hofstadter, in a different context, has described as "much more the character of Veblen's 'conjectural history' than of full-fledged historical sociology" (Hofstadter, 1968:14). My own work, in contrast, was based on a detailed analysis of primary sources, and this enabled me to go beyond simply asserting what can sometimes appear to be merely an anti-professional ideology, for I was able to demonstrate, via an examination of the contemporary debates among medical practitioners, that restriction of entry to the profession was a consciously articulated goal of many of those who campaigned for medical registration.

It should be noted that I did not argue, in the way in which Berlant for example argued, that professionalization can be understood simply in terms of a monopolization strategy, for this would be greatly to oversimplify what was a complex process which was also associated with broader social changes over which medical practitioners had little or no control (1984:179). My general conclusion, in relation to the significance of registration, was as follows:
those writers who have argued that the 1858 Act [which established
the General Medical Council and which required the Council to
keep a register] was passed for the benefit of the public have
offered at best a grossly oversimplified account of the significance
of registration, for they have ignored not only the fact that the
profession derived significant monopolistic advantages from
registration but equally importantly the fact that these monopolistic
advantages were clearly recognised within the profession from the
very beginning of the campaign for registration (1984:152).

iii) In examining the relationship between the development of sports
medicine and the use of performance-enhancing drugs (Waddington and
Murphy, 1992; Waddington, 1996), I suggested that there was a very close
connection between these two processes. More particularly, I argued that,
whereas one aspect of the public perception of the sports physician - and this
view is, not surprisingly, encouraged by sports physicians themselves - is that
of an expert who plays a vital front-line role in the fight against what is
commonly regarded as the abuse of drugs in sport, the reality is rather more
complex. Specifically, I argued that the growing involvement of sports
physicians in high performance sport has increasingly involved them in the
search for championship-winning or record-breaking performances, and that
this has led some sports physicians to play an active part in the development
and use of performance-enhancing drugs. I concluded that:

far from being one of the key bastions in the fight against the use of
performance-enhancing drugs in sport, sports medicine has
actually been one of the major contexts within which performance-
enhancing drugs have been developed and used. In this sense, it
may be said that the development of performance-enhancing drugs
and techniques is not something that is alien to, but something that
has been an integral part of, the recent history of sports medicine

iv) In a forthcoming paper on "Sport and health" I critically examine
what is probably one of the most widely accepted ideologies of the late
twentieth century, namely the ideology that participation in sport is good for
one's health. This ideology, it might be noted, is widely and generally
uncritically accepted in, and also forms a basis for social policy in, developed
and developing societies, capitalist and communist societies and democratic
and totalitarian societies. In my paper (which is presented as additional
supporting evidence for this Ph.D. submission) I seek to analyse the different
patterns of social relations associated with non-competitive exercise and sport,
and also with different kinds of sport, and to examine some of the
physiological consequences of these social differences, in terms of the rather
different impacts which sport and exercise can have on health. My
conclusion about the relationship between sport and health is again a
sceptical one:
In general, it is probably reasonable to suggest that in the case of rhythm ic, non-competitive exercise where body movements are, to a relatively high degree, under the control of the individual participant, the health benefits substantially outweigh the health costs. However, as we move from non-competitive exercise to competitive sport, and as we move from non-contact to contact sport, so the health costs, in the form of injuries, begin to mount. Similarly, as we move from mass sport to elite sport, the constraints to train longer and more intensively and to continue competing through pain and injury also increase, with a concomitant increase in the health risks. The health-related arguments in favour of regular and moderate exercise may be overwhelming, but such arguments are rather less persuasive in relation to sport in general, and very much less persuasive in relation to elite, or professional, sport.

Organization of the published material.

The material submitted for the degree of Ph.D. has been organized in three sections. The three sections represent slightly different aspects of my work, though the organization of the material also reflects a temporal dimension with my earlier work concentrated largely in the first section while my more recent work is presented in the final section.

Section One contains a selection of my essays on the development of the medical profession in the eighteenth and nineteenth centuries. Most were published prior to the publication of my book in 1984, the two exceptions being the essay which was published in Germany in 1985 and the essay I was invited to contribute to the British Medical Journal in 1990; in both cases, however, the research on which these papers was based was carried out prior to the book’s publication. These essays may, therefore, be said to represent my early work in the historical sociology of medicine.

Section Two contains the text of my book, The Medical Profession in the Industrial Revolution (1984). The publication of the book was an important watershed, for it represented the culmination of my work in this area and also enabled me to draw together some of the themes of my earlier work - for example, those relating to medical ethics and the changing market for medical care - and to integrate these themes into a broader and more coherent approach to understanding the professionalization of medicine. I felt that, with the publication of the book, I could move on to examine a number of other problems within the sociology of medicine.

Section Three contains a selection of essays dealing with these “other problems” within the sociology of medicine. Perhaps inevitably, the essays in this section are more diverse than those in Section One, though they are all, to a greater or lesser degree, concerned with more practical, or more policy oriented, issues. They are also, with one exception, relatively recent articles, with only one essay dating from the earlier period, prior to the publication of
my book. This essay is the one on social class inequalities in health which dates from 1977, and it may be helpful to say a brief word about the background to this paper.

In 1976 the then Labour Government appointed a Royal Commission on the National Health Service, chaired by Sir Alec Merrison. I was concerned that the major inequalities in health and health care which had been documented in the sociological literature should be examined as part of an official enquiry (the Black Report, which examined these issues in great detail, had not then been commissioned). Accordingly, I submitted a brief note on inequalities in health as evidence to the Royal Commission, as a means of trying to get this issue onto the agenda, and was subsequently invited to submit a longer paper on the subject. This I did, and I was later approached by Professor Jean McFarlane, Professor of Nursing at Manchester University and a member of the Royal Commission, with a request to publish an edited version in the Journal of Advanced Nursing. A concern with questions of equity in health care also underpins my pamphlet Revolution is Health, which was published by the Nicaragua Solidarity Campaign Health Network in 1989 (a copy of this pamphlet is submitted as one of two supporting documents).

The paper written with Sue Dopson (1996) is an explicit attempt to theorise, in terms of an Eliasian framework, some of the difficulties involved in developing and implementing policy decisions in the National Health Service while, in the two papers on drugs and sports medicine (1992; 1996), and in the forthcoming paper on sport and health (copy submitted as a supporting document to the published work), I combine my interests in the sociology of health and the sociology of sport to address some relevant policy related issues.

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REVOLUTION IS HEALTH

An introduction to health and health care in Nicaragua

Ivan Waddington

Nicaragua Solidarity Campaign Health Network
The cover photograph shows a rural health post in northern Nicaragua. Photo: Steve Smith/Andes Press Agency.
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ACKNOWLEDGEMENTS

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Finally, I wish to thank the many people within Nicaragua - Ministry of Health officials, doctors, nurses, brigadistas, patients and many others - all of whom were extremely generous with their time, and in the help and information which they provided. In this context, it might be noted that a Ministry of Health official even provided me with a typescript copy of a newly completed and at that time unpublished analysis of the previous year’s vaccination campaigns. If the Department of Health in Britain were only half as helpful in making information available, the task of health researchers in Britain would be very much easier than it is!
1. Introduction: Revolution is Health.

By the entrance to the Aldo Chavarria Hospital in Managua stands a large sign proclaiming "Revolution is Health". The sign draws attention to an important truth about health in Nicaragua, for there is an intimate relationship between the revolution which overthrew the Somoza dictatorship in 1979 and subsequent improvements in health. In the first place, the reforms in the health care system since 1979 should properly be seen as only one part of a much wider package of reforms, including land reforms and increased educational provision, which were initiated by the new Sandinista-led government and which were designed to help the poorer groups - particularly the rural peasants and the urban poor - within Nicaraguan society. Secondly, it is also clear that as far as these groups are concerned, improved health and health care - particularly improvements in the health of infants and young children - have been among the most tangible benefits of the revolution. These achievements in the field of health have been recognized by international health organizations such as the Pan-American Health Organization and the World Health Organization, and by internationally respected aid organizations such as Oxfam.

This pamphlet describes some of the major changes in health and health care which have taken place since 1979. It consists of three major sections. The first section provides a brief outline of health and health care under the Somoza dictatorship in the years prior to 1979. This is followed by an outline of the major reforms in the period from 1979-84. The third section examines the period from 1984 to the present and focuses, in particular, on the impact on health and health care of the U.S.-funded contra war, and of the associated economic crisis within Nicaragua.
2. Health and health care under the Somoza dictatorship.

Health and health care cannot be divorced from the wider society of which they are a part. Inequalities in health and in access to health care tend to be most marked in those societies in which inequalities in other areas — for example, in the distribution of income, wealth and power — are also particularly great. Nicaragua under the dictatorship of Somoza was a prime example of such a society.

During the four decades prior to 1979, Nicaragua was ruled by the dictatorship of the Somoza family which had extensive holdings in agriculture, industry and building, and which treated the country almost as a personal fief. By the mid-1970s, the Somoza family owned 21% of all agricultural land, whilst the Somoza Banking Group extracted funds from state institutions to boost the family investments in construction materials, meat packing, tobacco products, shoes, rice production, real estate, mass media, auto sales and auto parts (Donahue 1986: 12). Following the massive earthquake in the capital, Managua, in 1972, Somoza became infamous for the expropriation of international aid for personal gain. Somoza’s National Guard became equally notorious for the ruthless tactics used to suppress political opposition; assassination and torture of political opponents were common occurrences. Moreover, large Somoista landowners involved in the agro-export business could count on the support of the National Guard if they sought to expand their landholdings by forcing peasants off the land (Collins 1985: 17-18).

In many ways, the health care system reflected these massive inequalities within the wider structure of Nicaraguan society. Strictly speaking, one can hardly refer to a proper health care “system” as such, for
Public health services were provided by no fewer than twenty-three separate organizations, a situation which made it virtually impossible to adopt a co-ordinated national plan to attack health problems. These twenty-three institutions included the Ministry of Health, the National Assistance Board, some nineteen local Social Welfare Boards, the Social Security Institute and the Military Hospital.

Of these organizations the largest, in terms of expenditure, was the Social Security Institute (INSS) which in 1974 spent over 50% of the total health sector budget. However, INSS had developed primarily in order to provide health services to workers in the state bureaucracy, and to a lesser extent to those in relatively secure urban employment; in 1978, it provided health care to just 16% of the economically active population, and just over 8% of the total population. Other areas of health expenditure reveal a similar concentration of resources on relatively small sections of the population, particularly the better off middle classes in urban areas. Thus in 1974, the Ministry of Health, which had formal responsibility for the entire population of Nicaragua and sole responsibility for the rural population, spent 75% of its entire budget in Managua, which had just 25% of the population (Garfield and Taboada 1984: 1139). This pattern of expenditure was symptomatic of a policy of spending what limited resources were made available for health on expensive hospital care in urban areas whilst neglecting the more basic need of the urban and rural poor for primary care. Thus whilst the level of hospital provision under Somoza was actually quite high by Central American standards - in 1977 there were fifty hospitals and clinics with a level of provision of 2 beds per 1,000 population - there were only five health facilities with beds in rural areas, most of which lacked even the most basic primary care facilities (Rosset 1982: 261-2).
As a consequence, one of the outstanding features of the health care system under Somoza was its highly inegalitarian structure, with an estimated 90% of medical services directed to just 10% of the population. In marked contrast, only about 25% of the population had regular access to any kind of qualified health care (Halperin and Garfield 1982: 389). In rural areas, almost 80% of those providing health care were traditional midwives (patronas) or traditional healers (curanderos), all of whom worked without any public sector support (Donahue 1986: 10). One indication of the low level of coverage of the pre-revolutionary health care system is provided by the fact that only 25% of deaths had medical certificates (Escudero 1980: 647).

With high levels of child malnutrition, with an illiteracy rate of over 50%, and with most of its population left without access to primary health care, it is not surprising that pre-revolutionary Nicaragua was characterised by very high rates of morbidity and mortality. Precisely how high these rates were is difficult to say, since the Somoza regime made no effort to establish proper procedures for the routine collection of data on health. One slightly ridiculous indication of the inadequacy of government statistics under Somoza is provided by the fact that between 1973 and 1978, the number of deaths reported from tetanus exceeded by between ten and twenty times the total number of registered cases of the disease (Congreso Nacional de las JRS, 1984: 5-7). As one specialist in social medicine has observed in relation to Somoza's Nicaragua, "A country which lacks studies of morbidity, which has carried out few nutritional surveys, and whose system of medical attention for the population is absolutely insufficient is a country which cannot know the diseases which affect it with any certainty" (Escudero 1980: 649).

Despite these difficulties, it is possible to arrive at what are probably...
reasonably accurate estimates of some of the key health indicators during the Somoza period. Two points should be made in this respect. The first is that the official figures provided by the Somoza government to international organizations were patently false and were not accepted by any of those organizations. The second point is that there is considerable agreement amongst those organizations as to the probable real level of certain important indicators of health under the Somoza regime.

According to information provided by the Somoza government to the World Health Organization, the crude death rate in 1977 was 8.2 per 1000 population. However, WHO properly disregarded this figure, and estimated the real death rate at 13.2 per 1000. Estimates of infant mortality provided by the Somoza regime were even more misleading. The officially recorded infant mortality rate for 1977 was 53.2 per thousand live births. This figure was clearly false. For the period from 1973 to 1977, WHO estimated the real infant mortality rate at 120 per thousand (WHO 1980: 99). This is in line with an estimate from the Latin American Demographic Centre (CELADE) for a slightly earlier period of 121 per thousand, with mortality of children under the age of two reaching 149 per thousand (Escudero 1980: 648). The current Nicaraguan government accepts an estimate of the infant mortality rate of 121 per thousand for the pre-revolutionary period. Expectancy of life at birth in the 1970s is generally accepted to have been about 52 years (MINSA 1986:11).

This, then, was the structure of health and health care inherited by the new Sandinista-led government following the overthrow of the Somoza dictatorship in 1979. In the next section, we examine some of the major changes initiated by the Sandinistas in the period up to 1984.
3. Health care reforms, 1979-84.

Shortly after the revolution of 1979, health was declared one of four priority areas for government action, along with defence, economic development and education. In the period up to 1984, that commitment was expressed in, amongst other things, a steadily expanding health care budget; from 1977 to 1984, the proportion of the government budget allocated to health care increased from 8% to 14% (MINSA 1986: 12). Perhaps of even greater importance, however, have been the redistributive aspects of government policy, with a relative shift of resources away from high-cost urban facilities catering for comparatively small segments of the population, and towards the creation of a network of primary care facilities providing basic care to the urban poor and the rural peasants.

One of the first acts of the new government, in early August 1979, was to create a single National Unified Health System (SNUS) which brought together the twenty-three formerly separate health care institutions into a single system under the control of the Ministry of Health (MINSA). This was an important step, for it made it possible - for the first time in Nicaragua - to develop and to implement a properly co-ordinated health care plan on a national level.

However, for the first year or so, there were few signs of the development of a national integrated plan of this kind, as most of the work of the Ministry was taken up with emergency responses to the health care needs which had arisen as a result of the civil war in 1975. The lessons learned in this initial period were to have an important influence on subsequent health care policy.

During the civil war, over 40,000 people had been killed and around
100,000 injured (Donahue 1986: 23). Many of the survivors required forms of treatment which were only available within hospitals, thus increasing the demand for hospital care at a time when the number of available beds had decreased, for in the last months of the civil war the National Guard had destroyed, damaged and looted a number of hospitals (Garfield and Halperin 1983: 193). The immediate response to this crisis was a conventional and familiar one. In 1980, an emergency hospital construction programme was launched, with financial assistance from Sweden and West Germany. By the following year, however, it was recognised that this represented an inappropriate health care strategy for a developing country and a new strategy, involving a greatly expanded role for primary health care, was developed.

In initiating this policy change, the Nicaraguan government was following the strategy for primary health care recommended by the World Health Organization. In a series of reports since 1978, WHO has consistently and persuasively argued that high levels of hospital provision represent an expensive and particularly inappropriate form of health care investment for developing countries (WHO 1978 and 1981). Their central argument hinges around the fact that the major threats to health in these countries come not from the diseases of affluence such as cancers and heart disease, but from those of poverty - mainly infectious and parasitic diseases - many of which can be prevented or cured by relatively simple, inexpensive techniques, often using locally available resources. The most effective way of combating this pattern of disease - particularly given the limited resources available for health care in developing societies - is not one which involves heavy investment in costly and sophisticated hospitals in urban areas, but rather one which places the emphasis on relatively low cost and often low
technology primary care available to the whole population. WHO argues that the emphasis should therefore be placed on such things as the provision of safe water and basic sanitation, maternal and child care, immunization against the major infectious diseases, health education and appropriate treatment for common diseases and injuries. Such a strategy, WHO notes, is not only more equitable in that it avoids a heavy concentration of resources on small sections of the population, but it is also the most cost-effective way of using scarce resources to reduce the high levels of morbidity and mortality in developing societies.

In the months immediately following the overthrow of Somoza, the Ministry of Health was, not surprisingly, in a state of some administrative disarray. Whilst the health-care system had been radically reorganized with the creation of a single integrated structure, the new government had inherited very little from the Somoza regime in terms of established procedures for the routine collection and analysis of statistical data. It is almost certainly the case that without these procedures - which are of course a prerequisite for effective planning - the Ministry of Health had little idea of the real cost of the hospital construction programme on which it had decided. However, when the Ministry began to draw up its first systematic budget in 1980, it discovered that the cost of maintaining that programme would, on its own, use up the whole of the Ministry's allocated budget (Bosmert 1982: 269). It was clear that such a policy, if maintained, would make it impossible for the government to fulfil its wider goal of bringing health care to the poorer groups in Nicaraguan society, many of whom lacked access to even the most basic health-care facilities. This was one of the considerations which led, in 1981, to a radical change in health-care policy. In that year, it was decided to curtail the programme of
hospital construction which had begun in 1980 (Donahue 1986: 43), and by late 1981 the Ministry of Health, with assistance from WHO and UNICEF, had begun to formulate a new health care strategy which involved a greatly expanded role for primary health care workers.

In the development of this new strategy, the role of the Division of Communication and Popular Education in Health (DECOPS) was of major importance. DECOPS was formed as a department within the Ministry of Health in March 1980, and was composed largely of health educators who tended to stress the social as well as the purely biological aspects of health and illness, and who also tended to stress the importance of preventive rather than simply curative measures. As part of the hugely successful literacy campaign of 1980 - a campaign which reduced the level of illiteracy from 52% to 12%, and for which Nicaragua was awarded a UNESCO prize (Miller 1982: 245) - DECOPS was given the task of preparing some 200,000 copies of a leaflet on "Health lessons for literacy workers", and training over 12,000 volunteer literacy workers in malaria prevention and treatment (Donahue 1986: 26). The success of this campaign suggested the possibility of using large numbers of volunteer health workers who, after a brief training period, could provide important elements of primary health care. Many thousands of these volunteer health workers (brigadistas) have subsequently been trained, and they have played a major part in the delivery of health care, particularly in remote rural areas.

DECOPS was also given the task of developing popular health councils at local, regional and national levels. These are composed of representatives from the Ministry of Health and representatives of the "mass organizations", of which the most important, in terms of their participation in health programmes, are the Sandinista Defence Committees which are organized at
neighbourhood level, the national women's organisation (AMNLAE), and the
unions representing health service workers (FETSALUD) and teachers (ANDEN).
The development of popular health councils, together with regular face-the-
people meetings between government officials and people, have provided a
means through which both the mass organisations and local communities can
participate in the formulation and implementation of health care policy.

What, then, have been the major characteristics of this primary care
strategy? The element of primary health care for which Nicaragua has become
most noted - and which has excited most interest from international
organizations as a potential model for other developing societies - is
undoubtedly the mass vaccination campaigns against diseases like polio,
whooping cough, tetanus and tuberculosis. Before we look at these campaigns,
h owever, it may be useful to examine briefly one early but slightly different
campaign which, like the mass vaccination campaigns, was based on the
mobilization of large numbers of brigadistas. This was the mass drug
administration campaign against malaria in November, 1981 (Garfield and
Vermund 1986).

In the preparation for the campaign, more than four thousand workshops
were held in which over 73,000 anti-malaria brigadistas were trained to
conduct a census, provide door to door education about malaria, promote
community participation, package and distribute drugs and keep records. These
brigadistas in turn recruited other volunteers, and it is estimated that
about 10% of the total population took an active part in the campaign. Some
2,300,000 people - 87% of the total population - were counted in the malaria
census, and 1,900,000, or about 70% of the population, received anti-malarial
drugs which were administered simultaneously throughout the whole country
over a three day period. Though the campaign did not on its own constitute a
long term solution to the problems posed by malaria, which remains a serious health threat in many parts of Nicaragua, it did have a number of important benefits. In the four months following the campaign, there were 9,200 fewer cases of malaria than would normally have been predicted for that time of year, whilst the information obtained through the national malaria census made it possible for the Ministry of Health to identify more precisely high transmission communities as the basis for future campaigns. The campaign also resulted in a greatly increased awareness of malaria and of the problems associated with mosquito breeding sites. Perhaps most important, however, was the fact that the campaign reflected an unprecedented level of involvement of the general population in health care activities, and the experience of organizing widespread community participation was to prove invaluable for the many subsequent mass vaccination campaigns involving large numbers of volunteer workers.

The development of the mass vaccination campaigns in the period from 1980-84 is illustrated in Table 1 and in Figure 1.

<table>
<thead>
<tr>
<th>Vaccinations (number of doses), Nicaragua, 1980-84.</th>
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<tbody>
<tr>
<td></td>
<td>1980</td>
<td>1984</td>
</tr>
<tr>
<td>Polio</td>
<td>538,178</td>
<td>2,072,000</td>
</tr>
<tr>
<td>DPT (diphtheria, whooping cough, tetanus)</td>
<td>384,949</td>
<td>629,000</td>
</tr>
<tr>
<td>Measles</td>
<td>101,829</td>
<td>273,000</td>
</tr>
<tr>
<td>BCG (tuberculosis)</td>
<td>81,228</td>
<td>124,000</td>
</tr>
<tr>
<td>TT (tetanus toxoid)</td>
<td>827,763</td>
<td>1,118,000</td>
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</tbody>
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Figure 1. Vaccinations (number of doses), 1980 and 1984.

Many of these vaccines are distributed on special health campaign days which are known as "popular health work days" (jornadas populares de salud - JPS), and which are a distinctive feature of the Nicaraguan health care system. There are several such campaign days each year, and on each jornada the aim is to vaccinate people in high-risk groups - especially young children - against a particular disease. Each jornada is preceded by massive publicity, and most of the vaccinations are carried out by brigadistas. As can be seen from Table 1 and Figure 1, there was a substantial increase in the number of vaccines administered between 1980 and 1984, with a marked emphasis on vaccination against the infectious illnesses of infancy and childhood, several of which constitute serious threats to health and are the cause of many deaths in most developing societies. By 1983 vaccines against both tuberculosis and polio were being administered to 88% of children under the age of one (MINSA 1986: 12). This is indeed a remarkable achievement for a poor country with an underdeveloped infrastructure.

It is important to note the part played by the jornadas in the vaccination of infants and young children. In 1980, virtually all vaccinations were provided through the regular curative health care system, but by 1983 around 80% of anti-polio vaccinations and more than 50% of vaccinations against measles were being provided through the health campaigns (Garfield and Taboada 1984: 1163). It is clear that the jornadas - and therefore the brigadistas - form a critically important part of Nicaragua's primary health care strategy.

There is clear evidence to indicate that the vaccination campaigns have had a significant impact in terms of reducing the incidence of a number of serious childhood illnesses. The outstanding success in this respect is probably provided by the example of polio. The campaign against polio, of
which there had formerly been outbreaks every two or three years, has taken on the characteristics of a national crusade, with the number of vaccinations quadrupling between 1980 and 1984. The campaign has also been very successful, for no new cases of polio have been recorded in Nicaragua since 1981 (see Figure 2). Those people who have been disabled by polio are now all aged 8-9 or over, and reflect the epidemiology of polio prior to the revolution.

A second substantial success story is provided by the changing epidemiology of measles. In the period prior to the revolution, measles was an extremely common disease. When it was contracted by children who were already suffering from malnutrition, it could also prove fatal; between 1973 and 1977, the annual number of recorded deaths from measles varied between 112 and 321 (Congreso Nacional de las JIS, 1984: 15). The paucity of health information collected under the Somoza regime does not allow us to make a precise estimate of the average yearly number of cases, but it is clear from the mortality figures that in each year from 1973 to 1977 there must have been several thousand, and perhaps several tens of thousands, of cases. This situation began to change in the years immediately following the revolution. In 1980 there were 3,784 cases of measles, but between 1980 and 1983 more than 676,000 children under the age of six were vaccinated (Congreso Nacional de las JIS, 1984: 13), and the proportion of children under the age of one who were vaccinated increased from 15% in 1980 to 47% in 1984 (MINSA 1986: 12). This campaign was associated with a very substantial decrease in the incidence of measles (see Figure 3). In 1983, there were just 112 cases of measles, which meant that the total number of cases in that year was substantially below the average number of deaths from measles - 197 per year - in the period from 1973 to 1977.
Figure 2. Polio number of vaccinations and number of cases, 1980-84.

Figure 3. Measles number of vaccinations and number of cases, 1980-84.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>CASES</td>
<td>3,784</td>
<td>224</td>
<td>220</td>
<td>112</td>
<td>153</td>
</tr>
<tr>
<td>DOSES</td>
<td>101,829</td>
<td>225,932</td>
<td>205,313</td>
<td>209,939</td>
<td>273,000</td>
</tr>
</tbody>
</table>

Alongside the development of the vaccination campaigns, priority has also been given to other aspects of low cost but effective primary care. For example, diarrhoea was - and indeed still is - a major problem in a country where much of the population lacks access to potable water and proper sanitation facilities. Initially 170 oral rehydration centres for the treatment of diarrhoea were planned, but popular demand and community action quickly brought the number up to 225. In the first 21 months of the programme, these centres treated 91,000 children for diarrhoea (Halperin and Garfield 1982: 390).

By 1984, a network of primary health care centres and more simple health care posts had been established throughout most of the country. The total number of primary care facilities had increased from 172 in 1977 to 487 in 1984 (MINSA 1986: 12), with many of these being located in rural areas to provide basic health care to the peasant population. The result was that by 1984, an estimated 80% of the population had regular access to primary care (Garfield and Taboada 1984: 1141).

In line with the policy of giving priority to the development of primary care, the growth of hospital provision has been much more restrained. Over the whole period from 1977 to 1984, there was a modest increase in the total number of hospital beds, though it seems that all of this increase came in the period prior to 1982, for there was actually a net loss of 140 beds as a result of economy closures in the period from 1982-84 (Donahue 1986: 50). The overall increase in bed provision has, therefore, been relatively limited, and has failed to keep pace with the rate of population growth over the same period; as a result, whilst there was a modest increase in the absolute number of beds, there was actually a slight reduction of bed provision in relation to population size. Hospitals continue to take a
large but declining share of the total health care budget, and there is some
evidence to suggest that this policy has been associated with a shift in the
location in which consultations take place. Thus in 1980, 60.5% of all
consultations took place in health centres and health posts and 39.5% in
hospitals; by 1983, the former had increased to 66% whilst the latter had
decreased to 34% (Donahue 1986: 53).

There are also other signs of a better - that is to say a more
equitable - distribution of resources. Between 1977 and 1982, the annual
number of consultations in Nicaragua more than doubled, from just under 2½
million to more than 6 million, with the largest increases taking place in
formally underserved areas. Thus in Managua, which was by far the best
served area in the country, the annual average number of consultations per
inhabitant increased from 2.1 to 2.7; in the most underserved areas - Regions
1, 3 and 6 - the increases were considerably greater, from 0.2 to 2.0, from
0.2 to 1.3 and from 0.3 to 1.7 respectively. This development was also
associated with a relative decline in Managua's former dominance of health
care provision, for whereas in 1977 64% of all consultations had taken place
in the capital, by 1982 this figure had declined sharply to 38% (Donahue

There is therefore evidence of a shift in health care priorities, with
greater emphasis being placed on the provision of primary care and
preventive care, and with the development of a more equitable system. What
has been the effect on health of this change in policy? All of the usually
accepted indicators suggest that this change has been associated with an
unusually rapid improvement in the health of the Nicaraguan people. Whilst
there have been spectacular successes in relation to particular diseases,
with polio being the outstanding example, there is also clear evidence of
more general improvements in health, particularly in the health of infants and young children, who are particularly vulnerable to the diseases of poverty, and who have been the major target groups for many primary care programmes. By 1984, the infant mortality rate had been reduced from the pre-revolutionary level of around 120 per thousand live births to 71.5 per thousand and, associated with this, expectation of life at birth had increased from around 52 years to 59 years (MINSA 1996:12). The Nicaraguan Government received considerable international recognition for these achievements in the field of health, most notably in the form of election to the presidency of the Pan-American Health Organization advisory council, and in the selection in 1983 by the World Health Organization as one of five model countries for primary health care (Garfield 1984).

However, in the period since 1984, the task confronting health workers has been made immeasurably more difficult by the direct and indirect consequences for health of the escalation of the contra war against Nicaragua, a war which has been funded by the United States government in defiance of a ruling by the International Court of Justice that such actions by the U.S. were illegal in international law. The next section examines some of the more important consequences which the war has had on health in the period since 1984.
4. Health and the contra war.

In recent years, all aspects of Nicaraguan society have been profoundly affected by two closely inter-related processes, namely the escalation of the contra war in the years after 1984, and the associated economic crisis within Nicaragua. By 1987, these two related problems had become the fundamental constraints on health and health care provision.

The most obvious and direct impact of the war has been in terms of the large number of war casualties. Over the whole period from 1980-86, the mortality rate as a direct result of military action averaged 83 per 100,000 population, and given the sharp increase in the number of war deaths in the years after 1984, this was by 1986 almost certainly the major single cause of death amongst 15-45 year old males (MINSA 1987: 16). In addition to these deaths, there are also the huge problems, both human and economic, of rehabilitating the large number of people who have been left permanently disabled by the war.

A further direct consequence of the war has been the displacement of 250,000 persons as a result of contra action in rural areas. This has not only involved considerable social disruption, but has also necessitated substantial government expenditure on resettlement programmes. In addition, it has also produced increased strains on already over-stretched services - most notably housing and transport - in some of the urban areas which have received displaced persons.

In the period after 1984 it also became increasingly difficult to deliver health services in regions affected by war. The ability of the government to deliver health care in even relatively remote areas has been one of the great success stories of the post-revolutionary period and,
almost certainly because of this, the disruption of health services in rural areas became one of the objectives of the contras. In contravention of the Geneva Convention, health workers in remote areas became direct targets of contra attacks. By the end of 1987, thirty-four salaried health workers (25 doctors and 9 nurses) had been killed by the contras, whilst a further thirty-four had been kidnapped and twenty-five wounded (Central America Information Bulletin, 15.6.88). In addition, many brigadistas have been killed, wounded or kidnapped. A number of health facilities have also been lost as a result of contra attacks; by the end of 1985, fifty health facilities, including one hospital and four health centres, had been destroyed or abandoned as a result of contra action, leaving 225,000 people without access to health care (MINSA 1985: 9).

The war has also had a major impact on Nicaragua’s economy, and this in turn has had serious implications for health. Nicaragua is currently experiencing an economic crisis which is closely associated with the war. The government has recently estimated the cost of the direct damage of the war at $7,158 million (Barricada Internacional, 11.2.1989). This figure, it should be noted, is a minimal estimate of the economic cost of the war since it includes only the direct costs in terms of physical damage, production losses, loans blocked by the U.S. and losses as a result of the U.S. trade embargo. In addition to these direct costs, the war has imposed a number of other major strains on the Nicaraguan economy. Thus, to cite one obvious example, the war effort has inevitably involved the diversion of resources away from much needed development projects and into military expenditure, with the result that by 1986 military spending was taking some 55% of the total government budget (Close 1986: 104-5). It should be noted that this massive burden has been placed upon the Nicaraguan economy...
during what was already a difficult period economically for most countries in Latin America, for in the 1980s virtually all countries in the region have experienced severe foreign debt and export problems, largely as a result of falling export prices for primary products and changing patterns of international trade and aid. As a result of this combination of circumstances, Nicaragua has been unable to maintain the rate of economic growth - 3.3 per cent - which it exhibited between 1980 and 1984 (Close 1988: 82); indeed, largely because of the escalation of the war from about 1984, the economic crisis facing Nicaragua has become increasingly acute, and in recent years real incomes have been falling.

The war's indirect effects on health - that is to say, the effects on health as a result of the war's impact on the economy - have been numerous and far reaching. The health problems created by these economic difficulties may be illustrated by reference to two local case studies undertaken in different parts of Nicaragua. One of these case studies relates to levels of nutrition, the other to the provision of water supplies and sanitation.

In 1987, Scottish Medical Aid for Nicaragua sponsored a study of malnutrition and the child growth monitoring programme in the small rural town of Belén, in southern Nicaragua (Pearson and McCormick 1988). Whilst the evidence of the study was not directly comparable to evidence relating to the pre-1979 period, it did suggest that children were better nourished than was the case prior to 1979. However, the study also indicated that malnutrition remains a serious problem, with 18% of children under the age of two suffering from some degree of malnutrition, as assessed by low weight for age. The authors noted that although Belén is not located in one of the war zones, levels of nutrition in the town had nevertheless been adversely affected by the war as a result of the disruption of agriculture.
and the resultant decrease in food supplies. It should be noted that the contra, recognizing the importance of food supplies, made food storage facilities regular targets for attacks, particularly after 1983. Not surprisingly, the economic impact of the war has been most directly felt in serious declines in the production of primary products, and by 1986 these losses amounted to 14% of primary sector production (Close 1988: 102). This has inevitably had an adverse impact both on exports of primary products and on the level of food consumption within Nicaragua.

The second case study was undertaken in thirteen rural villages in northern Nicaragua, and examined the relationship between the incidence of diarrhoea and the provision of potable water and sanitation facilities (Stormoglpson 1986). The study's first finding was to confirm that diarrhoea is extremely common in many parts of Nicaragua. It was calculated that, taking all thirteen communities together, children under the age of six had on average nine episodes of diarrhoea a year, with young children between the ages of one and two being particularly at risk with, on average, no fewer than sixteen episodes per year. The second major finding was that the provision of water and sanitation facilities has a very significant impact on the incidence of diarrhoea. In one of the villages studied, El Caracol Terroneda, it was possible to compare the incidence of diarrhoea prior to and after the completion of a water and latrine project which involved the construction of a single hand-dug, cement-covered well, and the installation of latrines in most houses. It was found that the project resulted in a reduction in the incidence of diarrhoea of between 63 and 83 per cent.

The Nicaraguan Government is very much aware of the importance of water and sanitation projects, and between 1979 and 1985, the proportion of the population living in houses with piped water increased from 35% to 46%.
Further progress in this area has however been slow because of a shortage of resources. In 1987 the Government indicated that the war and the economic crisis were placing severe constraints on the further development of water and sanitation facilities, (MINSA 1987: 3) and since that time the economic difficulties facing Nicaragua have become even more acute. The shortage of resources for development projects of this type is arguably the single most serious consequence, in health terms, of the economic crisis, for diarrhoea is the cause of no fewer than 30% of post-neonatal deaths (deaths from one month to one year), and it remains the leading cause of death amongst all infants under the age of one (MINSA 1988a: 6). It should also be noted that this is not an isolated example, for a number of other development projects with important implications for health have similarly been hit by the economic crisis.

Notwithstanding these enormous difficulties, the Ministry of Health has made a determined effort to maintain its primary health care programme, with the mass vaccination campaign remaining a high priority. Figures relating to the vaccination campaigns in the three year period from 1985 to 1987 are shown in Table 2 and in Figure 4.

<table>
<thead>
<tr>
<th>Table 2. Vaccinations (Number of doses), 1985-87.</th>
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<td>Year</td>
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<td>Polio</td>
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Figure 6. Vaccinations (number of doses), 1985-87. 
Target figures for 1987 indicated a continuing high level of coverage of polio and BCG vaccines, with a substantial increase over previous years in the number of vaccinations against measles and DPT. In addition, there was a considerable expansion planned for 1987 in the provision of tetanus vaccine to adults, with the major target groups being expectant mothers and women in the child-bearing age groups.

As indicated previously, many of these campaigns have been noted for their high level of coverage of at-risk groups, and some of the reasons for this success became clear when the author was able to observe a vaccination team at work during a study tour to Nicaragua in May, 1987. The occasion was a "popular health day" at San Juan del Sur on the Pacific coast.

Although San Juan del Sur is only a small town with a population of just 6,700, there were no fewer than 13 temporary vaccination posts established in the town for the day. Each post was staffed by an auxiliary nurse and two brigadistas, and each team had a list of 80-90 children requiring polio vaccine. During the morning, the health team worked in the health post - in this case a schoolroom - and by mid-day half the children had been brought to the health post and vaccinated. The health team then took the vaccine in an ice-box and walked to the scattered houses on the outskirts of the town in search of the missing children. After several hours of walking in the afternoon heat, the health workers finally returned, having found and vaccinated all but two of the children on their list. On the day in question, there were 2,500 temporary vaccination posts established throughout the whole country, whilst 19,000 brigadistas took part in the campaign (El Nuevo Diario, 16.5.87).

Throughout the 1980s, Nicaragua has continued to co-operate with and to enjoy the support of WHO in developing its primary health care strategy.
In 1985, the UNICEF/WHO Joint Committee on Health Policy named Nicaragua as one of eight developing countries which was making a "clear and continuing commitment to implement the primary health care approach" and recommended that the health care programmes in these countries be given additional support (WHO 1987: 64).

The difficulties associated with the war and the economic crisis have meant that, almost inevitably, improvements in health since 1984 have been much less spectacular than were those in the period from 1979 to 1984. In 1985 there was a further slight fall in the infant mortality rate to 69 per 1000 live births (World Bank 1987: 258), while the latest official estimate, for 1986, puts the figure at 66.7 per 1000 (MINSA 1988a: 1). More recent unofficial estimates from field workers in Nicaragua suggest that since that time the infant mortality rate has remained fairly stable at around 65 per 1000.

Notwithstanding the substantial gains which have been made in health since 1979, the Ministry of Health remains acutely aware of the fact that preventable diseases continue to take a heavy toll in infant and child deaths. With this in mind, the Ministry launched a new campaign in June 1988, with the object of achieving a further significant reduction in mortality amongst infants and young children (MINSA 1988a and 1988b). The campaign involves a variety of governmental and non-governmental organizations at national, regional and local levels, with the broad outlines of the national plan being adapted at the local level to meet particular local circumstances.

The campaign is being targeted at children under the age of five, and particularly at those under the age of one, and at expectant and feeding mothers. It involves a number of inter-related elements, amongst which are
included the following:

1. Water and sanitation projects. Given the shortage of capital resources, the emphasis is being placed on projects which can be developed using appropriate low cost technology to supply water in rural areas. Local communities will be encouraged to construct latrines, while major campaigns are also being launched to clear up refuse and to control rats, mosquitoes and other vectors.

2. Nutrition. Nutritional projects include: the development of supplementary feeding programmes for expectant mothers, for children under the age of one, and for other children in high risk groups; a campaign to encourage mothers to breast feed their children in order to reduce the incidence of both malnutrition and diarrhoea; programmes of nutritional education, and a variety of plans to boost food production, e.g. the development of vegetable gardens on small plots of land surrounding factories in towns.

3. Education. Targets have include the reduction of illiteracy, particularly among women in the child bearing age group, and the use of the mass media to provide basic information about health and hygiene, and to try to change existing unhygienic habits.

4. Pregnancy and childbirth. In addition to seeking further improvements in both the quality and the coverage of care during pregnancy and childbirth, the campaign also involves a number of other educational and family planning elements. These include the promotion of (i) smaller families, ideally of not more than three children, and (ii) adequate intervals between pregnancies. It is also hoped to reduce the number of pregnancies in the higher risk age groups, i.e. adolescents and women over the age of thirty-five.
Health care provision. Major objectives in relation to health care provision include the further development of the vaccination campaigns against polio, measles, DPT and BCG, with the object of vaccinating at least 80% of children under the age of six in each locality. The programme of immunisation against tetanus for women in the child bearing age group is also being extended. It is also planned to target resources on reducing mortality from a limited number of diseases - most notably diarrhoea and respiratory infections - which account for such a high proportion of infant and child deaths.

It is important to note two particular aspects of the current campaign. The first of these is that, like previous campaigns, it is very labour intensive and is dependent on the participation of large numbers of brigadistas and other volunteer workers. This is, for example, very obvious in relation to the vaccination campaigns, but also in relation to urban clean-up campaigns and vector control programmes, and in relation to community based water and latrine construction projects. For this reason, the Ministry of Health has stressed that community participation is essential to the success of the campaign and, as in previous campaigns, the mass organisations are expected to take a major part in encouraging and organizing community involvement.

The second point to note is that the campaign has very clearly been constrained by considerations of cost. A glance at the major elements of the campaign indicates that the Ministry of Health has put together a package of inter-related projects, none of which requires a large amount of additional finance which, in the current situation, is simply not available. However, the economic crisis within Nicaragua is so serious that it is by no means clear that adequate funds can be found, even for a relatively low cost.
campaign of this kind. At the time the campaign was launched, for example, the Director of the Ministry of Health for Region 1 told a representative of the Nicaragua Health Fund that although funds were available for the continuing education of the brigadistas, there were serious problems in transporting workers to the countryside, for out of ten vehicles used in an earlier campaign in May 1988, five had been damaged by the poor road conditions, and there were major difficulties in obtaining spare parts. He also reported that though they had adequate supplies of vaccines, there was a shortage of disposable syringes, whilst the mother and baby monitoring programme was being hampered by a shortage of basic equipment such as step-on scales. Finally, it was by no means clear that the Ministry would even be able to provide a basic allowance for food and lodgings for brigadistas who had to travel away from home. (Sarah Jackson, personal communication.)

What has been said above can do no more than hint at the immense difficulties which confront health workers in Nicaragua on a day-to-day basis. Given these difficulties, it is hardly surprising that little further progress appears to have been made in reducing infant mortality rates since about 1986, for since then health workers have had to run very hard just to stand still. As noted earlier, recent reports from fieldworkers in Nicaragua suggest that in the last two or three years the infant mortality rate has remained fairly stable at around 65 per 1000. If this is indeed the case, then it means that, notwithstanding the lack of further progress since 1986, the Nicaraguans have been able to hold on to the health gains made in the earlier period. Given the circumstances which have prevailed in Nicaragua in recent years, this should itself be regarded as a very considerable achievement.
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USEFUL ADDRESSES.

Nicaragua Solidarity Campaign,
23 Bevenden St.,
London E1 6BH.
Ph. 01 253 2464.
National membership organisation which aims to raise political and material support for the FSLN (the Sandinista National Liberation Front) and the people of Nicaragua.

Nicaragua Solidarity Campaign Health Network,
c/o NSC, at the above address.
Provides a link for activists interested in solidarity with Nicaragua on health related issues.

Nicaragua Solidarity Campaign Women's Network,
c/o NSC at the above address.
A network for women and women's groups working in solidarity with women in Nicaragua.

Nicaragua Health Fund,
83 Margaret St.,
London E1 6BH.
Ph. 01 580 4295.
A registered charity set up to support health projects in Nicaragua aimed at meeting emergency needs and to support new health programmes.

Scottish Medical Aid for Nicaragua,
The Volunteer Centre,
25-27 Elmbank Street,
Glasgow G2 4PB.
Ph. 041 226 3411.
Aims to raise awareness in Scotland of the situation in Nicaragua and to provide financial support and medical personnel for health centres in Nicaragua.