Proceedings of the British Academy, **78**, 149–163

Medical Values in a Commercial Age

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EVEN the phrase 'Victorian values' is a reminder that historians write about themselves as well as the past. A volume with this title has different reverberations for us than it would have had for a historian of Lytton Strachey's generation, and even the inclusion of a paper on medicine testifies to recent changes in historical perceptions and practice. Neither science nor medicine rated a chapter in G.M. Young's *Early Victorian Britain*, and only three decades ago, Walter Houghton's *Victorian Frame of Mind* contained but one brief reference to medicine and only cursory material on what is now seen as a much more central Victorian preoccupation: health.[1] The army doctor and sanitary reformer Edmund Parkes (1819–1875) was speaking as a Victorian as much as he was as a doctor when he urged young doctors 'Never [to] think of your life, but always of your health, which alone can make life useful'.[2]

Parkes's coupling of health and usefulness was high praise indeed, for usefulness could easily have served alongside *Duty*, *Thrift* and *Self-Help* as a marketable volume by that quintessential Victorian Samuel Smiles, himself of course originally a trained doctor. In fact, an episode in Smiles's early career points to the theme which I shall discuss here. After a medical

Read 13 December 1990.

[1] G.M. Young (ed.), *Early Victorian England, 1830–1865*, 2 vols (London, 1934); Walter Houghton, *The Victorian Frame of Mind, 1830–1870* (New Haven, 1957).

[2] Quoted by J. Russell Reynolds, 'The Value of Competition', in *Essays and Addresses* (London, 1896), p. 241.

apprenticeship and formal medical study at the University of Edinburgh, and a European jaunt for a quick M.D., Smiles returned to his native Haddington, to pursue a career in medicine. He abandoned Haddington after six years, being, as he recalled, 'among 3000 healthy Scotsmen and in competition with seven other doctors'.[3] Ever the optimist, Smiles settled in Leeds, turning shortly to journalism and then to the writing of those books which so captured the spirit of his age. The doctorate which he proudly displayed on the title pages of his later books was not of the medical variety, but an honorary LL.D. – a higher one in the Victorian scale of values.

Competition in the medical market-place is my theme, then, and while the Victorian medical profession was never so cohesive as to be able to adopt anything like – to use one of our own cant phrases – a 'strategic plan', that profession was, willy-nilly, perhaps, reasonably successful in adapting itself to the changing economic and social circumstances of Victorian Britain. The most striking features of this adaptation were the growth of an occupational diversity and the increasing reliance on the state as an important patron. In that sense, the 1911 National Health Insurance Act was simply a culmination of processes which had been in train at least since the New Poor Law of 1834.

Before examining the variety of medical responses to the spectre of competition, I must mention briefly two matters of relevance: the continuing legacy of individualism, and the size of the medical profession itself.

First, individualism: whatever criteria one chooses as essential defining characteristics of a profession – autonomy, esoteric knowledge, even a rhetoric of altruism – it is clear that Victoria's reign was the crucial period for doctors.[4] Furthermore, it seems to me that recent historical attempts to disparage the 1858 Medical Act as a failure, or worse, because it perpetuated too much of the *status quo*, are all wide of the mark. Irvine Loudon has recently shown that the opportunity for radical transformation of the structure of the medical profession had been missed – in the 1830s and early 40s – and that we should not therefore be surprised that the Act that ultimately came into effect tinkered less than radicals like the doughty Thomas Wakley (1795–1862)

[3] T.K. Monro, *The Physician as Man of Letters, Science and Action* (Glasgow, 1933), p. 116; elsewhere, Smiles recalled that there were in Haddington 'more than enough [medical men] to doctor double the population'. (Thomas MacKay [ed.], *The Autobiography of Samuel Smiles, LL.D.* [London, 1905], p. 60).

[4] A standard sociological analysis is Eliot Freidson, *Professional Dominance* (New York, 1970).

might have wished.[5] On the other hand, it seems ironic to see the Act historically in terms of conspiracy and monopoly, as Jeffrey Berlant has done, when the chief source of medical disquiet at the time was that the Act had failed to protect medical men (and the public) adequately from irregulars and quacks.[6] Admittedly, the Act bestowed on regular medical men certain advantages in the medical market place, but it never gave them, nor was it intended to, a monopoly on the individual doctor-patient transaction.

And that was crucial, for the values of the profession at large – both before and after 1858 – placed a premium on the individual encounter between doctor and patient: on the practice, for a fee, of curative medicine. Country surgeon-apothecaries of an earlier generation had been happy enough to call what they did a 'business',[7] and while the professional rhetoric might have been modified in the course of the century, it was still largely through private practice that reputations and fortunes were made, and professional honours secured. The Royal College of Physicians of London had twelve presidents during Victoria's reign, and only with the election of Sir William Jenner in 1881 did it acquire a president who could be described as scientifically distinguished.[8] Even Jenner maintained a large consultancy practice as well as appointments at Victoria's court, the usual pattern for College presidents. It could be argued with some justification that the College of Physicians was a sleepy, conservative place, outside the mainstream of significant professional change.[9] Nevertheless, London continued to act as a medical magnet throughout the century and the leaders of the profession were to be found among the fellowship of the London Colleges.[10] Further, despite

[5] Irvine Loudon, *Medical Care and the General Practitioner*, 1750–1850 (Oxford, 1986); the best description of the long series of acts and successive Parliamentary debates is Charles Newman, *The Evolution of Medical Education in the Nineteenth Century* (London, 1957); a recent attempt to assess the Coleridgean influence on one of the Act's chief architects, John Simon, is T.N. Stokes, 'A Coleridgean against the Medical Corporations; John Simon and the Parliamentary Campaign for the Reform of the Medical Profession 1854–8', *Medical History*, **33** (1989), 343–59.

[6] Jeffrey Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* (Berkeley, California, 1975), pp. 153ff, sees the Act as liberal in conception but monopolistic in actual consequence.

[7] A point stressed by Loudon, op. cit. (note 5), pp. 100ff.

[8] The Presidents are listed in vols 3 (p. 343) and 4 (p. 603) of *Munk's Roll*, begun by William Munk and continued by a succession of editors (London, 1878 *et seq.*) where short biographies of them will also be found.

[9] George Clark, *A History of the Royal College of Physicians of London*, 2 vols (Oxford, 1964–6) is a tactful account of the College's history until 1858. A third volume, on the later history of the College, was written by A.M. Cooke (Oxford, 1972).

[10] Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley, California, 1978).

the increasing occupational diversity, to be examined more fully below, private solo practice was the model to which most medical students would have aspired and would have hoped, after a few years, to have achieved.

In reality, not all of them could succeed. Was this because there were too many of them? Certainly this was a common complaint from the medical men themselves in the decades before the Medical Act, and one which continued to be voiced throughout the century.[11] An overcrowded profession was bad for the doctors and bad for their public. Doctors suffered a loss of income, patients suffered a loss of quality in their care since, so the argument ran, this professional surplus was always to be found in the dregs of their ill-educated, incompetent colleagues (who rarely managed to get their opinions into print). The real problem, however, especially before 1858 but not solved even then, lay in alternative providers of medical care: quacks, irregulars, practitioners with alternative medical cosmologies, and, perhaps most important, the chemists and druggists who took it upon themselves to sell medicine directly to the public.[12] Despite the economic liberalism of the age, many doctors wanted the state formally to outlaw all unorthodox or alternative practitioners, as a danger to the public's health, and the government's refusal to do this was seen by some as irresponsible. At the very least, they wanted to confine competition to the fraternity itself.

On the other hand, the Medical Register, created by the 1858 Act, did at least and at last officially set the standards by which the fraternity was to be identified. It also required members of it to stand up and be counted if they wanted to benefit from the confidence which the public was supposed to have in the profession. On paper, the Medical Register eased the problem of overcrowding: the census of 1851 enumerated 19,190 medical practitioners, in a population of 17,927,609, or one out of 935 people. The corresponding figures for 1861 are 15,297 in a population of 20,066,224, or one in 1,312.[13] The diminution in the absolute number of individuals calling themselves medical men was a function of the new criteria in effect between 1851 and 1861. Thereafter, for the rest of the century, the ratio of practitioners to population varied but modestly. The

[11] Loudon, op. cit. (note 5), ch. 10; F. Musgrove, 'Middle-Class Education and Employment in the Nineteenth Century', *Economic History Review*, (n.s.) 12 (1959–60), 99–111.

[12] A recent monograph and two collections of essays survey this general area: Roy Porter, *Health for Sale: Quackery in England, 1660–1850* (Manchester, 1989); W.F. Bynum and Roy Porter (eds), *Medical Fringe and Medical Orthodoxy 1750–1850* (London, 1987); Roger Cooter (ed.), *Studies in the History of Alternative Medicine* (Oxford, 1988).

[13] For figures from 1841 to 1971, see Loudon, op. cit. (note 5), p. 309.

drop between 1851 and 1861 was a result of the Medical Act, since after 1858 it was not legal to identify oneself as a 'medical man', even for census purposes, without possessing at least one of a number of the qualifications specified by the Act.

Crude figures like these do not mean too much, since they say nothing about how many of these practitioners were active or how they were distributed throughout the country. Nevertheless, they do suggest that Samuel Smiles was either unlucky in his choice of a place to establish his practice, or exaggerated the extent of his competition, since his figures would give only 375 patients for each doctor in Haddington in the 1830s. There were irregularities of distribution, of course, – London always had more than its share, for example – but as Squire Sprigge remarked in 1905, the very fact that the ratio of population to doctors had been more or less constant for more that forty years, implied that it was 'inherently right'. He at least had no truck with whinging colleagues who complained of too much competition.[14]

Given the structure of the educational institutions and the licensing bodies, there was no chance that numbers would be regulated by the profession itself. Hospital medical schools, university medical faculties and the medical corporations each needed student fees to survive, and more fees to thrive. In the United States, a similar situation produced the pseudo-academic proliferation of proprietary schools offering cut-price degrees.[15] This never happened in Britain. For one thing, the separation of teaching and examination functions between the hospital medical schools and the medical corporations meant that most students were examined by people who had not necessarily taught them. This might have produced an ideal system of checks and balances, though in practice the situation was not nearly so neat. For instance, the universities could both teach and examine, and university medical degrees were registrable in the same way as membership or the licentiate in one of the royal colleges or the Society of Apothecaries. Until about 1850, overwhelmingly the most important university medical school, in terms of degrees, was Edinburgh; the University of London had oppressively and deliberately high standards, with very low pass rates, until the last decades of the century, and the medical schools in Oxford and Cambridge began gradually to attract more students only from

[14] S. Squire Sprigge, *Medicine and the Public* (London, 1905), ch. 2.

[15] Two recent monographs survey medical education in the United States: William G. Rothstein, *American Medical Schools and the Practice of Medicine* (New York, 1987), and Kenneth M. Ludmerer, *Learning to Heal: the Development of Medical Education* (New York, 1985).

the 1860s.[16] Only a minority of the rank and file possessed university medical degrees even by the end of the century, although the present trend was by then well underway. The General Medical Council, created by the 1858 Act, probably did more than its enemies charged, and less than its advocates pleaded, in settling and maintaining educational standards.[17] Its direct powers were limited, but its very existence and functions occupied pride of place in various late Victorian descriptions of the profession, and Sir George Newman was convinced that medical, legal and lay people were unanimous: the General Medical Council had 'achieved order and efficiency in place of chaos and injustice in the profession'.[18]

There existed no single mechanism to regulate professional numbers, and only the barriers of entrance standards and fees could control the size of the cohort setting out in quest of a medical career. The most famous study of what actually happened to medical students was that published in 1869 by (Sir) James Paget (1814–1899), the St. Bartholomew's Hospital surgeon and pathologist. He collected information on the subsequent careers of 1,000 students whom he had taught at Bart's between 1839 and 1859, and concluded, roughly, that about 10% met with either outstanding or considerable success, another 50% with 'reasonable' success, and about 12% with 'limited' success. The remainder – 280 – either failed in their careers, abandoned medicine early, or died during their education or shortly thereafter. In addition, he was unable to trace the whereabouts of another 226, many of whom were probably among the less successful. Consequently, his findings were perhaps more cheerful than the rigours of the profession warranted. The only student which Paget singled out by name was one of his less than successful protégés, the poisoner Dr. Palmer, who had been 'an idle, dissipated student, cursed with more money than he had either the wisdom or the virtue to use well'.[19] A generation later, Squire Sprigge repeated the exercise on a more limited scale, tracing the careers

[16] For London, see Negley Harte, *The University of London 1836–1986* (London, 1986); for Cambridge, cf. Sir Walter Langdon-Brown, *Some Chapters in Cambridge Medical History* (Cambridge, 1946); Sir Humphry Rolleston, *The Cambridge Medical School* (Cambridge, 1932); and Arthur Rook (ed.), *Cambridge and its Contribution to Medicine* (London, 1971). A.J. Engel, *From Clergyman to Don, the Rise of the Academic Profession in Nineteenth-Century Oxford* (Oxford, 1983), barely mentions medical education.

[17] Dr. Russell Smith of the University of Melbourne is presently working on a history of the General Medical Council.

[18] George Newman, *The Building of a Nation's Health* (London, 1939), p. 67; cf. Squire Sprigge, op. cit. (note 14), ch. 1.

[19] James Paget, 'What Becomes of Medical Students', reprinted in Stephen Paget (ed.), *Selected Essays and Addresses by Sir James Paget* (London, 1902), pp. 27–32; cf. Stephen Paget, *Memoirs and Letters of Sir James Paget* (London, 1902), pp. 244–5; and Peterson, op. cit. (note 10), pp. 133–5.

of 250 students who had entered St. George's Hospital Medical School, beginning from 1879. His general conclusions were roughly comparable to Paget's: of 250 students, 63 – about a quarter – failed to qualify for a variety of reasons; from the remaining 187, Sprigge judged that 116 had achieved outstanding, reasonable or fair success, 23 had died within 12 years of qualification and only six had come to grief, including two who ended up in prison. He was unable to say anything about the careers of 20 who were still on the Medical Register, but the fact that they were there implied to him that they were earning some sort of a living through medical practice.[20]

These numbers could be variously interpreted, though both Paget and Squire Sprigge chose to see them in a rosy light, as indicating that medicine offered a good career choice, if only for the energetic and ambitious young man. Following the medical life, Squire Sprigge insisted, was 'worth the candle'. On the other hand, both men were conscious that their own medical schools, Bart's and George's, were prestigious metropolitan institutions and that comparable figures for other medical schools might not be so favourable. In addition, individuals whose careers were untraceable were excluded, and these were unlikely to have been professionally successful. Paget attempted to explain away what could seem to be relatively high death rates for young adults, but neither commented on the fact that the bulk of the professional wastage occurred early on. This was only partially a consequence of the examination system; only a small fraction of those who failed professionally did so because they were unable to pass their exams. Nevertheless, the elaboration of a much more extensive and, so contemporaries believed, searching examination structure was a striking feature of Victorian society, including its medical profession.[21] Even the Royal Colleges, hardly notorious for advocating meritocracies, were forced to change, through the replacement of oral examinations by written ones, the extension of subjects to be examined, and the emergence of mechanisms whereby examiners were appointed as a result of competence rather than seniority.[22] More generally, examining became

[20] Squire Sprigge, op. cit. (note 14), ch. 2; Squire Sprigge returned to the theme, with some figures collected by Edward Corner for St. Thomas's Hospital students from 1890–9, in an essay entitled 'Prizes and Performances', in S. Squire Sprigge, *Physic and Fiction* (London, 1921), pp. 148–75.

[21] For a general overview, see Robert J. Montgomery, *Examinations: An Account of Their Evolution as Administrative Devices in England* (London, 1965).

[22] A.L. Mansell, 'Examinations and Medical Education: the Preliminary Sciences in the Examinations of London University and the English Conjoint Board, 1861–1911', in Roy MacLeod (ed.), *Days of Judgement: Science, Examinations and the Organization of Knowledge in Late Victorian England* (London, 1982); Loudon, op. cit. (note 5), pp. 171–88; W.J. Reader, *Professional Men* (London, 1966), ch. 3; Newman, op. cit. (note 5).

itself a kind of mini-industry, providing welcomed income and prestige, and not-so-welcomed drudgery in roughly equal portions.[23] Title pages of medical works often singled out examination appointments alongside hospital and academic posts, an indication of the value the profession began to place on the former.

The competitiveness of the system was explicitly celebrated in prize-giving ceremonies, which, with the opening of session, was one of the two red-letter days in the medical school's annual calendar. Each was occasion for inspirational platitudes, and Prize-Day gave eminent representatives of the profession and of public life more generally opportunity to reflect on such themes as 'The value of competition', the title of Sir John Russell Reynolds' address to the medical students in Bristol in 1885. He reminded his charges that the public rewards of medicine were not so great as those of the church, the bar, or the armed forces, but that the private gratitude of their patients and their patients' families and friends could compensate. It was these latter who would continue the lifelong examination merely begun in medical school: fail your patients and you will fail your profession and in your profession.[24]

Embodied in such injunctions, and in the hierarchies of success by which Paget and Squire Sprigge classified their peers, was the recognition that, in the end, private practice was the most pervasive touchstone. Paget judged 'distinguished success' to have been achieved by obtaining, in this order, 'a leading position in practice in great cities', a place on the honorary staff of a large hospital, an academic chair or some important public office. In reality, attainment of any of the latter three was unlikely except in conjunction with the former. Russell Reynolds singled out three of his contemporaries as worthy of emulation: E.A. Parkes, Sir William Jenner and Sir John Simon. They may be more commonly remembered as a sanitarian, hospital consultant or civil servant, respectively, but each began as a private practitioner and continued to see patients in that capacity for much or all of his career. Of the trio, Parkes (1819–1876) had the least interest in private practice, partly because his health was always delicate and

[23] Becoming an examiner in physiology and comparative anatomy for London University in 1856 was one of several posts which helped the young T.H. Huxley cobble together a scientific career. cf. Leonard Huxley, *Life and Letters of T.H. Huxley* (2nd edn, 3 vols London, 1903), I, pp. 213ff.

[24] Reynolds, op. cit. (note 2). A poignant comment on the phenomenon can be found in Shephard T. Taylor, *The Diary of a Medical Student During the Mid-Victorian Period, 1860–1864* (Norwich, 1927), entry for 28 June 1861: 'Distribution of prizes at the College [King's College London], but as there were no prizes for poor me, I purposely kept away.'

partly because his connexions with the army's medical service dictated frequent trips abroad, even during the decade (1849–1860) he was professor of clinical medicine of University College. However, as William Jenner, one of his memorialists, pointed out, he was 'a sound and able practitioner', who simply had not remained long enough in London to rise to the top of the consulting branch of the profession – 'we all know that success in practice is, to some extent, a question of survivorship'.[25] Simon gave up his private consulting rooms in the 1850s, but he retained his surgical consultancy at St. Thomas's until his retirement age.[26]

What the individual patient paying a fee to the individual doctor constituted – whether it was a shilling for an office visit to a poor general practitioner or five guineas or more for half-an-hour of a Harley Street consultant's time – was a vote of confidence. 'The public are our employers, and, in the long run, we shall be what our employers make us,' remarked Robert Brudenell Carter in 1903.[27] Within that context, internal competition was perceived as inevitable, even desirable, and was regulated by a complicated but informal code of intra-professional etiquette, governing such matters as second opinions and poaching patients.[28] Two other major sources of competition, one external and one internal, continued to plague the late Victorian profession. The external one was of course the unresolved one of what doctors still liked to call quackery.

In practice, the most serious economic threat was probably not that posed by unregistered individuals offering their services in the medical market place, whether these were homoeopaths, botanicals, nurses,

[25] William Jenner, 'Observations on the Work and Character of the Late Dr. E.A. Parkes, FRS', *Lancet* 1876, ii, 41–3, on p. 41.

[26] Royston Lambert, *Sir John Simon (1816–1904) and English Social Administration* (London, 1963).

[27] R.B. Carter, *Doctors and Their Work* (London, 1903), p. 13.

[28] Ibid., ch. 13 for an Edwardian discussion of medical etiquette; Squire Sprigge, op. cit. (note 14), pp. 243ff also touches on issues of 'second opinions'. An anecdote from Carter (pp. 291–2) illustrates the dilemma from the doctor's point of view: 'An old lady once consulted me, to whom I said that she must undergo an operation without avoidable delay, and who replied that she could not consent to so serious a proposal until she had taken a second opinion. I applauded her decision, and urged that the second opinion should be taken immediately. She assented, but went on to ask me to whom I should advise her to go. I was obliged to say that the answer must depend upon the opinion she desired to receive. If she wished for one which would encourage her to undergo the operation, I could tell her where to get that. If she wished for one which would encourage her in letting things drift, I could equally well tell her where to get that. She was a shrewd old lady, and, after looking at me for a minute with a rather puzzled expression, she said, "Perhaps I had better have it done." I thought so too; and the "second opinion" was not obtained.'

wise-women, or prescribing parsons, but the dispensing chemists and druggists, and patent medicine manufacturers.[29] Relationships between the medical profession and the Pharmaceutical Society were sometimes strained, as doctors complained that would-be patients were going directly to their neighbourhood chemist for advice and medicine, and pharmacists objected that too many doctors still dispensed medicines. As Squire Sprigge remarked:

> The Pharmaceutical Society very properly and strictly forbids its members to prescribe for patients or to take upon themselves the functions of the medical practitioner, but over the counters of scores of dispensing chemists every day and every hour there are given to the public medical advice and medical treatment.[30]

Proprietary medicines like Godfrey's Cordial or Carter's Little Liver Pills were available in a wide variety of shops, and a large mail-order market, often aimed at people suffering from 'shameful' conditions, like venereal disease, female troubles, sexual anxieties or unwanted pregnancies, was cultivated by advertisers. Bartrip has recently examined the *British Medical Journal*'s late Victorian and Edwardian campaign against 'secret remedies'.[31] As a profession, doctors were never entirely happy that the 1858 Act had not protected the public from what they liked to see as its own gullibility, though the more thoughtful of them recognized that they, the doctors, were not, and could not be, disinterested parties in the debate.[32] Late Victorian medical commentators found consolation in the belief that an increased public appreciation of the new scientific medicine would encourage Parliament to outlaw quackery, or at least diminish patients' appetite for quack remedies and self-medication.

A more subtle, internal source of competition also confronted the late Victorian profession: the abuse of the charity system by patients who could afford to pay for the services of a private practitioner. Charity

[29] This threat has been emphasized for the early nineteenth century by Loudon, op. cit. (note 5), ch. 6; a detailed local study is Hilary Marland, *Medicine and Society in Wakefield and Huddersfield, 1780–1870* (Cambridge, 1987), pp. 208–51; *idem*, 'The Medical Activities of Mid-Nineteenth-Century Chemists and Druggists with Special Reference to Wakefield and Huddersfield', *Medical History*, **31** (1987), 415–39.

[30] Squire Sprigge, op. cit. (note 14), p. 73. Significantly, he discussed this situation in a chapter entitled 'The Evils of Quackery'.

[31] P.W.J. Bartrip, *Mirror of Medicine, A History of the BMJ* (Oxford, 1990), pp. 189–202; for an example of a late Victorian entrepreneurial quack, cf. William Schupbach, 'Sequah: An English "American Medicine" – Man in 1890', *Medical History*, **29** (1985), 272–317.

[32] E.g. Squire Sprigge, op. cit. (note 14), p. 72: 'The opposition of the medical men to the quack, however legitimate, cannot be called disinterested, and therefore does not weigh with the public'.

was of course big business in Victorian Britain, among which the voluntary hospitals with their out-patient departments, specialist hospitals, lying-in charities, and dispensaries occupied pride of place.[33] These were aimed primarily at the provident poor, that large segment of the population sufficiently independent to fall outside the jurisdiction of the Poor Laws but sufficiently impecunious to be unable to afford the services of a private practitioner and, especially, the nursing and other expenses of a serious illness or operation. Members of the medical profession had a large stake in these establishments, of course, and honorary appointments were keenly sought. Nevertheless, the continued growth of the charity sector was viewed by many practitioners with alarm. Squire Sprigge rated the 'abuse of hospitals' on an equal par with the 'evils of quackery',[34] and radical reformers like the Liverpool doctor Robert Reid Rentoul wanted the whole charity system overhauled.[35]

The problem, as doctors perceived it, was the ease with which waged workers and members of their families could obtain free or cheap treatment through charity. Outpatient attendance in the London hospitals rose by more than 50% between 1887 and 1900, from just over one million to well over one-and-a-half million.[36] Most hospitals employed clerks to investigate the financial circumstances of their patients, and posted the maximum weekly wage which entitled patients to use the charity, or over which payment would be expected. Rentoul cited an enquiry conducted in 1875 by the Charity Organization Society at the Royal Free Hospital in London. Of 641 individuals presenting themselves for treatment at the out-patient department, 12 were deemed able to pay a private practitioner, 231 were eligible to subscribe to a provident society, 169 were suitable, 103 gave false addresses and 69 gave insufficient information.[37] On the other hand, policing patients was not easy, and, in any case, the more patients institutions saw, the easier external fund-raising was among benefactors. The perilous financial state of many charities encouraged them to accept money from whatever quarter, including paying patients and, especially towards the

[33] The standard account of hospitals in England, Brian Abel-Smith, *The Hospitals, 1800–1948* (London, 1964), is still useful if somewhat dated. A recent synthetic study of hospitals in London is Geoffrey Rivett, *The Development of the London Hospital System, 1823–1982* (London, 1986); for the Manchester area, see J.V. Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and its Region, 1752–1946* (Manchester, 1985).

[34] Squire Sprigge, op. cit. (note 14), chs 5 & 6.

[35] R.R. Rentoul, *The Reform of Our Voluntary Medical Charities* (London, 1891).

[36] The figure is quoted by Squire Sprigge, op. cit. (note 14), p. 58.

[37] Rentoul, op. cit. (note 35), p. 3.

century's end, from working people themselves.[38] In theory, the latter were the objects of the hospitals' charitable exertions. In Birmingham, over half the working population contributed in the 1890s through the Birmingham Hospital Saturday Fund, mostly at a penny a week. This raised close to £20,000 a year for the hospital, but the contributors naturally looked upon their contributions as a form of insurance which entitled them to use the hospital's services.[39] The spectre of municipalization of the voluntary hospitals was raised long before the coming of the N.H.S.

Rentoul wanted a strict separation of the charity and paying sectors and proposed a more systematic prepayment scheme for working men and their families who he thought should be more rigorously excluded from the voluntary hospitals and their outpatient departments. His proposals, made in the late 1880s and early 1890s, were debated by several local branches of the British Medical Association, but sympathy with the problem did not lead to widespread enthusiasm for his solutions.[40]

In the interest of protecting the profession from charity abuse, Rentoul would have had general practitioners offer what was effectively a collective package of basic care, a Public Medical Service, in return for an annual sliding-scale payment based on age and physical condition. Such a scheme would have benefited both doctors and their patients, he thought, and would have left charitable institutions with their original task of providing care for those too poor to pay for it.

Fee-for-service medical practice was still too important ideologically for doctors to make many of them wish to jump on a comprehensive Public Medical Service bandwagon. Nevertheless, in actuality, doctors were earning increasing amounts of money outside the context of fee-for-service practice. The old 'business of medicine' of the late eighteenth century was much more complicated by the end of Victoria's reign. Part of this was the result of the considerable increase, during the last quarter of the century, in contract and club practice.[41] This 'battle of the clubs', as a *Lancet* commissioner put it, divided the medical profession, particularly as doctors believed that many middle class families who could have afforded private fees were joining working class clubs. The General Medical Council

[38] In London, hospital charity was co-ordinated, from 1897, by the Prince of Wales' Hospital Fund for London, which became the King Edward's Hospital Fund after Victoria's death. This is discussed in Rivett, op. cit. (note 33), pp. 145ff. Dr. Frank Prochaska has recently completed a history of the King's Fund, as the charity is now called, which will be published by Oxford University Press.

[39] Squire Sprigge, op. cit. (note 14), pp. 60–2.

[40] Jeanne L. Brand, *Doctors and the State* (Baltimore, 1965), pp. 153–5.

[41] David G. Green, *Working-Class Patients and the Medical Establishment* (New York, 1985).

tried to neutralize the most competitive aspects of the situation in 1899 by reminding registered practitioners that advertising fee scales and canvassing for patients constituted unprofessional ('infamous') conduct.[42]

At one level, the ability of organized patient groups to command the salaried services of a general practitioner can be seen as a consequence of an overcrowded or at least a relatively weak profession; on the other hand, the guaranteed salary was a safe bet for a young practitioner and doctors complained that non-collection of fees could be as high as 40% for those practising in working-class areas. Either way, clubs offered an alternative to ordinary solo practice, and many of the structures which the clubs had generated were perpetuated after 1911.[43]

Much of the Victorian occupational diversification, however, occurred in the public sector. The growth after 1834 of the Poor Law Medical Services; after 1845 of the psychiatric network of county lunatic asylums; after 1848 of Medical Officers of Health; the merchant naval service; army, navy and Indian Medical services; a separate colonial medical service; prison, police and factory surgeons; public vaccinators and public analysts; coroners; medical inspectors of passenger ships and of seamen; each of these employed some or many medical men, but more by 1900 than 1850 or 1870.[44] The exact nature of the job, its terms, salary and security, varied widely of course, as did the kind of men likely to be attracted. Recruitment to what was called the Sanitary Service, especially in the larger

[42] Green, (ibid.), has argued that club practice worked well, although the picture of it painted by Squire Sprigge (op. cit., note 14) was much less favourable.

[43] A. Digby and N. Bosanquet have recently examined the economics of medical practice after the 1911 Act: 'Doctors and Patients in an Era of National Health Insurance and Private Practice, 1913–1938', *Economic History Review*, 2nd ser. **41** (1988), 74–94. See, also, N.R. Eder, *National Health Insurance and the Medical Profession in Britain, 1913–39* (London, 1982).

[44] I know of no work which attempts to examine systematically the phenomenon of medical occupational diversification in the nineteenth century, although aspects of it are considered by several of the authors already cited, viz. Loudon, Peterson, Squire Sprigge, Marland and Brand. For material on separate occupational groups, cf. Ruth G. Hodgkinson, *The Origins of the National Health Service* (London, 1967); Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in 19th Century England* (London, 1979); D.E. Watkins, 'The English Revolution in Social Medicine, 1889–1911', Ph.D. thesis, University of London, 1984; Neil Cantlie, *A History of the Army Medical Department*, 2 vols (Edinburgh, 1974); Chris Hamlin, *What Becomes of Pollution?: Adversary Science and the Controversy on the Self-Purification of Rivers in Britain, 1850–1900* (New York, 1987); Colin Russell, *Lancastrian Chemist: The Early Years of Sir Edward Frankland* (Philadelphia, 1985); Marguerite W. Dupree and M. Anne Crowther, 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century: the *Medical Directory* as a Historical Source', *Bulletin of the History of Medicine*, forthcoming; Marguerite W. Dupree, 'Other than Healing: Medical Practitioners and the Business of Life Assurance During the Nineteenth and Twentieth Centuries', paper delivered at the Autumn Conference of the Economic and Social History Society of Scotland, November 1989.

metropolitan authorities, was vigorous; the Poor Law Medical Officers were less successful as an occupational group and until the 1890s the army was notorious in its dealings with its medical officers.

Nevertheless, the very existence of this diverse group of employment possibilities undoubtedly aided in the task of cobbling together a decent living. Hilary Marland's detailed study of Wakefield and Huddersfield is instructive: in 1835, 35 medical practitioners were practising in these two localities and she was able to identify 23 public posts. In 1851, 47 practitioners were chasing 46 posts. In 1871, after the Medical Act, the practitioners numbered 38, while the posts had risen to 78.[45] Most of the posts were part-time and pluralism was obviously common. A random sample of 100 practitioners from the 1892 *Medical Directory*, 30 London and 70 provincial, revealed that 69 had identified themselves as holding or having held, a paid post or posts in the public or charity sector. I excluded resident physician or surgeon positions in voluntary hospitals, since these were becoming an accepted part of training. No fewer than 13 were or had been public vaccinators and the vaccination service had received £15,638 from central funds, in addition to the more routine contributions made at the local level.[46] Nationally, about 5% of the practitioners in Britain and Ireland were employed in the Sanitary Medical Service, and more than twice that number in the Poor Law Medical Service (also, since 1871, under the Local Government Board). The state even paid doctors for the notification of each case of 13 compulsorily notifiable infectious diseases, including smallpox, diphtheria and scarlet fever.[47]

It would be a mistake to conclude that, even by the century's end, medicine could compete with the Church, the Bar, or the Armed Forces, for the eldest sons of those who ruled Victorian Britain. Nor did the occupational diversity of the profession necessarily lead to greater unity. Even the United States has abandoned *e pluribus unum* as its motto. But diversification and state patronage were, I think, sources and consequences of strength. And no-one can read today Sir John Simon's *English Sanitary Institutions* without realizing that Victorian medicine had had its statesmen, most notably, perhaps, Simon himself. As the chief architect of that

[45] Marland, op. cit. (note 29), p. 276.

[46] The *Medical Directory for 1892* (London, 1892), p. 37; for the Victorian Vaccination System, cf. Lambert, op. cit. (note 26), esp. pp. 249–58 and 356–65; and *idem*, 'A Victorian National Health Service: State Vaccination 1855–71', *Historical Journal*, **5** (1962), 1–18. Compulsory vaccination provoked an organized resistance, which has been examined by R.M. MacLeod, 'Law, Medicine and Public Opinion: The Resistance to Compulsory Health Legislation 1870–1907', *Public Law*, Summer and Autumn 1967, 106–28, 188–211; and Dorothy and Roy Porter, 'The politics of Prevention: Anti-Vaccination and Public Health in Nineteenth-Century England', *Medical History*, **32** (1988), 231–52.

[47] W.M. Frazer, *A History of English Public Health, 1834–1939* (London, 1950), pp. 181ff.

alignment of the state and the profession between 1854 and 1876 he had changed the face of medicine. However, he also recognized that medicine was but one of many agencies devoted to combatting what he called the 'politics of poverty' in order to improve 'man's social existence'. For him, the essence of his age and that of his Queen was not simply new wealth and power; but rather 'the constantly increasing care of the community at large for the welfare of its individual parts'.[48]

[48] John Simon, *English Sanitary Institutions* (2nd edn, London, 1897), p. 485.