The movement towards the professionalisation of medicine

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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.¹ 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.²

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 denying those who were qualified a legitimate return on that investment. Qualified practitioners also pointed to the harm that unqualified practitioners

The travelling quack

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."³

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?"⁴ 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-

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"Doubtful Hope" by Frank Holl (1875)

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."⁵

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.² 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."⁶ 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.⁷

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 intraprofessional 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 intraprofessional 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 intraprofessional relationships, where conflicts were particularly likely to occur; the more obvious of these included such things as attending a patient of another

Were three heads better than one?

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practitioner, managing consultations between two or more practitioners, and regulating what were often delicate relationships between consultants and general practitioners.²

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

Clinical teaching at Charing Cross Hospital circa 1900

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1850s

- 1851: Hermann von Helmholtz invents the ophthalmoscope
- 1854: John Snow's brilliant epidemiological investigation of water supply in London and of an outbreak of cholera around the Broad Street pump in Soho establishes cholera as a waterborne disease
- 1856: Louis Pasteur's *Recherches sur la Putréfaction* establishes a “germ theory” of fermentation and putrefaction

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 master, 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.

- 1 Freidson E. *Profession of medicine: a study of the sociology of applied knowledge*. New York: Dodd Mead, 1970:71.
- 2 Waddington I. *The medical profession in the industrial revolution*. Dublin: Gill and Macmillan, 1984:140-1, 149-50, 153-75.
- 3 Peterson MJ. *The medical profession in mid-Victorian London*. Berkeley, Los Angeles and London: University of California Press, 1978:36.
- 4 Loudon I. *Medical care and the general practitioner 1750-1850*. Oxford: Clarendon, 1986:208.
- 5 Stacey M. *The sociology of health and healing*. London: Unwin Hyman, 1988:85.
- 6 Rivington W. *The medical profession*. Dublin: Fannin, 1879:2.
- 7 Percival T. *Medical ethics*. Manchester: S Russell, 1803.