

THE HISTORY OF THE MEDICAL PROFESSION: AIMS AND METHODS *

by

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IN RECENT years the study of medical history has been very active in England. Not only medical historians have contributed to it but others whose interest is in more general social history. There have been biographies and valuable new biographical works of reference. One after another, great medical institutions have found their historians: the hospitals, the London corporations, and one of those national institutions which provide their own medical services, the navy. Charity and charitable institutions have been studied with a new thoroughness and insight. For some periods we have learnt much about medical education and about the recruiting of the different branches of the profession. Statisticians have tried to discover from the census returns how the numbers and geographical distribution of the medical men were related to the economic development of the country. So in monographs and articles, and a few major books, materials are accumulating from which we can now begin to piece together the outline of something we have never possessed, a history of the medical profession in its various branches.

We are not yet in a position to generalize safely at a serious academic level about the activities of the many thousands of men and women who have belonged to the profession. There is still much to be done on the lines which are appropriate to the early stages of a new historical enquiry, that is by looking into separate subjects each of which disposes of a compact and accessible body of unexplored source-material. It is not by accident that we have so many biographies based on personal papers and so many histories of institutions based on their records. Two illustrations may show that much work of this kind remains to be done and can easily be taken in hand.

The first example concerns what is sometimes known, not at all appropriately, as the rank and file of the profession. From 1710 to 1803 an Act of Parliament¹ was in force which imposed a tax on all apprentices. The registers of the money so received contain a mass of facts about apprentices, their parents and their masters in all vocations all over the country. Two local record societies have published well-edited volumes dug from this mine.² They give us definite dates and facts about the careers of some dozens of surgeons and nearly twice as many apothecaries in Surrey and Wiltshire. They even tell us something about two physicians: John Standfield of Devizes apprenticed his son to a London surgeon in 1711; William Blizard of Lambeth in 1719/20 actually took an apprentice himself. At least two other local societies intend to publish similar books, and, as one of them is the London society, we may expect a very useful supplement to our knowledge of eighteenth-century practitioners in London. A study of the medical entries in the manuscript registers for all the counties and boroughs

* The Gideon Delaune Lecture, delivered in Apothecaries' Hall, London, on 30 March 1966. In this lecture the words 'medical' and 'profession' are used in the most widely inclusive sense.

¹ 8 Anne, C.5. The relevant clauses were repealed by 44 George III c.98.

² *Surrey Apprenticeships, 1711-31*, Surrey Record Society, X, 1929; *Wiltshire Apprentices and their Masters*, Wiltshire Archaeological and Natural History Society, xvii, 1961.

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would throw much light on the prehistory of general practice in this still obscure period.

The second example of straightforward work waiting to be done concerns some of the heads of the profession. Although throughout most of its history the profession has had no official hierarchy; there have been positions of honour which have enabled their holders not to give commands but to exert great influence. At some periods the most influential of these have been appointments at the royal court. It may therefore seem surprising that historians have often described this or that physician as physician to the king when he held no such office. It still happens: in a learned book published last year we are told that Peter Chamberlen the younger was physician to Charles I.³ I do not blame the author. Seven years ago I innocently followed the *Dictionary of National Biography* in describing Thomas Shirley or Sherley as physician in ordinary to Charles II.⁴ There is no full list in print of the medical households of the sovereigns, and, so far as I can hear, there is none in manuscript. It would be a perfectly simple matter to compile a list, with many details about dates of appointment, stipends and so forth, from the public records. The compiler would need to remember one fact which is usually overlooked. The queen has two medical households, one for England and one for Scotland. Although no sovereign between Charles II and George IV ever set foot in Scotland, appointments were regularly made and recorded there from 1660 to the present day. Hence it sometimes happens that an English historian says that some distinguished man was not physician or surgeon or surgeon-apothecary to the sovereign when he did enjoy that office north of the border.⁵

If all the easy preliminary tasks were done there would remain an indefinite number of possible lines of enquiry for which the evidence would be much harder to find. A Victorian worthy who died just a hundred years ago 'raised aural surgery', according to Sir D'Arcy Power, 'from a neglected condition of quackery to a recognized position as a legitimate branch of surgery'. It is also said that he was the first London aurist who raised his fee from one guinea to two. I do not know how to find documentary confirmation for that statement, nor for many others which contribute to our current ideas of the economic position and the status of medical men in former times. From the seventeenth century onwards we know a great deal about the houses medical men lived in and about their clothes and carriages; but in all such matters we could with advantage know more and know it more systematically. There is, for instance, the matter of sepulchral monuments. We can explain why the younger Hugh Chamberlen has one of the most ostentatious of the marble tombs in Westminster Abbey; but not perhaps why Sir Henry Halford thought it unsuitable for physicians to be buried there at all.

I share the feeling that we may easily have too much of the kind of medical history which may be called 'The Gold-Headed Cane and All That'; but as the materials for answering questions like these accumulate, brick by brick, we are able to frame provisional answers to some problems of professional history. We are beginning to see how and why the structure of the medical profession was modelled in some

³ C. Hill, *Intellectual Origins of the English Revolution*, London, Oxford University Press, 1965, p. 26.

⁴ Sir George Clark (ed.), *The Campden Wonder*, London, Oxford University Press, 1959, p. 10.

⁵ It is a pleasure to note that, since this lecture was delivered, lists of H.M. Ordinary Physicians (1568–1853) and of H.M. First Physicians (1603–1844) have been prepared in the Scottish Record Office.

ways on that of other professions and in its turn provided models for them; but far too little is known as yet about the development of the forms of professional organization. This is true both of major principles like the mutual exclusiveness of corporations and of devices like voting by ballot. We know that the churches, the law, medicine and the other professions are organized on very various lines, but we cannot tell which of the contrasts between the various callings arose from essential differences between them, nor can we tell which of the characteristics of medical organization have been moulded by the peculiar conditions of medical practice and which others have resulted from social causes affecting other callings as well. Beyond these lies the further question, how has it come about that the structure of the British profession is unique, unlike that in foreign countries in relation to the state, to the universities, to the pharmaceutical industry, and consequently to the public health and to patients? It would be interesting to survey the present state of our knowledge of these matters, but it would be of little practical use except to specialists because only those who are actively engaged in research can decide what lines it can profitably follow. A discovery may lead on to unforeseen investigations, but it may also show that some beaten track is a blind alley from which it is time to turn back. The general tendency or direction of research must, however, be kept under review, and in this the study of professional history has brought about a change of direction, or of emphasis. For a long time past, indeed from its very beginnings, medical history has taken the growth of medical science as its leading thread. We think of it as a coherent story of progress from primitive ignorance and superstition to the medicine of today and tomorrow. We trace it from book to book, or from experiment to experiment. Every profession has its own basis in knowledge, and its history must therefore include an element of intellectual history; but we are beginning to notice that we run into difficulties if we take this intellectual element as our only guide.

The first of these is the difficulty of obsolete science. We all know that in the past, even in the very recent past, practitioners used some remedies which did harm and some which at least did no good. Their light was darkness. Some historians think this blameworthy and call these practitioners callous or cruel. Others treat it as a joke, an instance of human folly. Some recognize uneasily that, if science is still advancing, the science of today is obsolescent and will be condemned or laughed at when its turn comes. The majority take refuge in speaking kindly of those imperfect methods which turned out to be stepping-stones to improvements in science, reserving their disapproval for the methods which have been superseded. But this leads to an embarrassing result. At certain stages of their history one or other of the constituted professional authorities resisted some innovation which ultimately turned out to be beneficent. We therefore find innumerable books in which institutions like the Paris faculty or the London corporations are severely censured for their intellectual obtuseness. Yet it is hard to reconcile this attitude with what we know about the education and the abilities of the individuals who were members of those institutions. And this difficulty about medical conservatism leads on to a second difficulty about the irregular practitioners, the impostors, the charlatans and the well-meaning amateurs. Some of these effected cures. A few did wonders. Some even anticipated what the orthodox afterwards came to discover or to do. Yet, the more we learn

about them, the less we are disposed to believe that the successes of the quacks discredit the science of which they were ignorant.

If we consider medical history not merely as an addendum to the history of science but as the history of the healing arts in their social setting, we find that, side by side with the intellectual factor, or rather interwoven with it, there is the second factor of professionally organized action. This second factor is an object of autonomous study, capable of making its own contribution to the integral history. This changed perspective corrects our view of the conflict between the intentions and the achievements of medical men in former times. Medical history tells how ordinary, fallible human beings have been piloted towards social purposes by institutions. Naturally there have been bad and stupid men amongst them, and morally good, intelligent men against them; but there has been a central highway of teaching and learning, of professional conduct, social service and the disinterested pursuit of knowledge. It is not only scientific superiority but adherence to this straight road which distinguishes the sound elements of the practice of any time and place from the unsound. It was, for instance, this rectitude as much as either rationalism or empiricism which rescued chemistry from alchemy.

We are beginning to see medical history in the context of the history of civilization. Every day we hear disparaging criticisms of almost all the things that we used to regard as the blessings of Western civilization; but there is one great achievement which detraction has spared. Everyone agrees that the West has conferred a benefit on the world by its wonderful medical discoveries. We think of these primarily as scientific discoveries, the knowledge which physicians and surgeons and their many allies apply in practice. We are indeed aware that a huge and intricate organization has been at work to enlarge and disseminate this knowledge. Most of us can form some picture in our minds of that far-reaching network of relationships. When a team of doctors goes into the jungle to give injections to the inhabitants under the auspices of the World Health Organization or of some philanthropic foundation, we can trace back the channels through which the doctors receive their appointments, their stipends, their general and special training, their equipment, their local information and everything else that they need. We can imagine how their journey has been immediately or remotely provided for by discussion and correspondence among such various authorities as government departments, the boards of directors of pharmaceutical manufacturers and instrument-makers, grant-giving foundations, and voluntary associations. Finally we come to the great public which bears the ultimate responsibility, whether its individual members act positively as subscribers to appeals or merely acquiesce as approving or reluctant taxpayers. We know that research, both for its actual progress and for its choice of objectives, depends on the same immense structure of co-operation. We can indicate in rough outline how the existing, and always changing, structure has developed historically from the institutions of simpler ages, such as university faculties, hospitals and privileged corporations. We can link our analysis of the existing machinery with our knowledge of professional history.

One of the keys to this continuity has received comparatively little attention from historians. Like all other scientific knowledge, medical knowledge is ethically neutral: it may be used for evil purposes as easily as for good. We know that it was used for

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evil only a few years ago on a vast scale and with fearful results; but we like to think of this as an aberration from which the world has recovered. Quite apart from that, any of us can cite horrible examples of medical men who used their skill to commit crimes or to conceal them. We know that there are many situations in which doctors, separately or in their assemblies, have to decide whether it is morally right to take a particular course of action or to pursue a particular line of research. But these realities scarcely colour our ordinary view of medicine. We think of them as exceptional. We think it natural, normal and inherently proper that medical knowledge is used for beneficent purposes. You will remember the title of the lecture by which the late Canon Raven inaugurated this Faculty seven years ago, 'Medicine the Mother of the Sciences'. That is a saying which some people are the more inclined to accept because it seems to imply that medicine has a bias towards good. Yet any such judgment, however attractive, is an historical statement and lies open to the ordinary processes of historical criticism. If medicine has been used almost exclusively in the service of humanity there may be a variety of alternative explanations. This harnessing may be the automatic result of something inherent in the nature of medical science. It may, however, be due to some necessary tendency of medical practice, perhaps a tendency of which practitioners themselves were only imperfectly or intermittently aware. Again it may be that those who acquired medical knowledge decided to use it thus and not otherwise. No one supposes that this was ever decided once and for all, but it may have been the cumulative result of literally millions of decisions spread through the course of history. To search for such decisions, or for necessary tendencies which eliminate the need for decisions, is one of the themes of the history of the profession.

That theme covers much of the same ground as the history of medical ethics. Historians often pay tributes to the wholesomeness of these principles and to their long continuity through the centuries, very commonly regarding them as an inevitable accompaniment of medical science. This assumption must be examined. We cannot indeed trace the origins of medical ethics. As the censors of the College of Physicians of London wrote in 1797, when they had occasion to reprimand a peccant apothecary, there are rules of practice which have been established from time immemorial. These rules were not, however, enacted at some unknown time and ever thereafter accepted without demur. Little seems to be known about challenges from within the profession, unless that word can be applied to malpractices which were nearly always concealed. From outside there were challenges enough, not only from the quacks and the cranks, but sometimes from the lawful guardians of society. In addition to challenges there have been movements of reform. We live now in an age of changes so fundamental that many people, sometimes from the highest motives, call the accepted medical ethics in question. Old principles such as clinical freedom, professional loyalty, professional secrecy and the paramount interest of the patient have to be developed and adjusted to meet new social exigencies. Even to maintain some of the received standards it is necessary both to fight for them and to define them afresh. But this is nothing new; it is the continuation of a process as old as medicine. I should like to illustrate the character of this process from an earlier age of ferment, the sixteenth and seventeenth centuries.

At that time there were political theorists of high authority who held that the

sovereign in a monarchy or the government in a republic had a moral right to use any means of destruction against its enemies. You may remember that Sir Thomas More's Utopians, in order to avert or diminish the bloodshed of warfare, resorted to assassination. They made away with the enemy's king, or those next to the king whom they regarded as responsible for the war. This was not mere theorizing: there were actual governments which killed without trial subjects whom they suspected of promoting rebellion or civil strife. The extreme case was the massacre of St. Bartholomew. On lesser occasions governments employed murderers, but these were not all barbarous ruffians like those in Shakespeare's plays. Physicians worked more discreetly, and there are records of some who did not scruple to do so. The Venetian republic kept an official poison cabinet which was supervised by pharmacologists.

Even those who were satisfied that such action was permissible at home and abroad might have doubts about its limits. In 1649 the Venetian *signoria* accepted a proposal of Dr. Michael Angelo Salomon, who undertook to infect the Turkish army in Crete with his quintessence of the plague. The official principally concerned felt it necessary to justify its use against the Turks only, by the argument that they were enemies by their religion and naturally treacherous.⁶ A few years later a famous Italian general went further. Although most of his service had been against the Turks, he advocated the discharge of pestiferous fumes and the communicating of contagious disease against any enemy.⁷

The doubts which lingered in the matter of biological warfare no longer restricted the use of conventional weapons, but a century earlier they were raised in much the same form about artillery. Nicolo Tartaglia, the founder of modern ballistics, wrote that he published his first book in view of the danger from the savage Turkish wolf, having given up the study and destroyed his notes a few years before because he reflected that it was blameworthy to improve the technique of damaging one's neighbours and destroying the human species, especially Christians.⁸ Now it would obviously require a whole book to trace the changes of opinion in these matters in those two comparatively simple centuries. It would require many books to answer the question how it has come about that the medical sciences are directed to diminishing sickness and sufferings of every kind, including those caused by war, while other sciences are used to inflict them. I believe that, among many favouring conditions which have concurred to produce this result, the will of the medical men themselves has been decisive; but I must regretfully admit that this is an historical hypothesis, not a conclusion proved by evidence.

Like the censors in 1797 we are accustomed to think of this will as embodied in a tradition which has come down from time immemorial. We find the tradition, already mature, centuries before the Christian era, in the Hippocratic Oath. If we could penetrate further back into the past, I believe we should see that a long process of thought and conscious will had gone to making it. The drafting of the Oath may well have given a programme and a rallying-point to one party in a hard contention. In

⁶ V. Lamarsky, *Secrets d'état de Venise* (1884), pp. 128–41. L. de Mas Latrie, 'De l'empoisonnement politique dans la republique de Venise', in *Mémoires de l'Institut: Académie des Inscriptions*, 1895, xxxiv, pt. 2, 197 ff.

⁷ R. Montecuccoli, *Opere*, ed. Grassi, i, 153.

⁸ *Nova Scientia*, 1537.

the end the principles of western medical ethics constituted a tradition, handed down from one man to another until our own time; but this was not merely something in the atmosphere which people inhaled unconsciously. It formed a part of regular medical education. Written texts, especially the Oath, were important in this teaching, though exactly how they were used is still a matter for research. You may remember that in 1961 the British Medical Association discovered, to the surprise of many people, that there was not a single one of the 31 medical schools of the British Isles in which newly qualified doctors were required to take the Oath. To a considerable extent the tradition has been handed on by word of mouth, both in the medical schools, and perhaps far more in the daily interchange of experience and ideas between older and younger doctors in practice.

Much of this is true of the ethical standards of other professions. Every profession has its own ethics. In the others, as in medicine, we sometimes see the sinister aspects of professionalism, such as obscurantism, love of power, love of gain or narrow *esprit de corps*. These phenomena are so well known that the cynics, including cynical historians, write as if the professions as such were rackets, exploiting the public and covering their frauds by hypocritical pretences. This analysis may be applied quite as plausibly to every other form of human organization, and it ought not to deceive us. The professional spirit at its best does not simply adapt the prevalent morality of a society to the special business of those who practise a particular art. On the contrary it helps to create that morality. The pervading social ethics are a compound formed by the interaction of many autonomous ethical systems alive within the social organism. It is easier to appreciate this in other examples than those of the professions. Perhaps it is easiest in the example of medieval chivalry. This was a code of honour, at first the private possession of a limited courtly and military class, which came by degrees to influence the manners and morals of much wider circles. It was derived from various sources, some of them Christian and some pre-Christian. In its prime in the Middle Ages it enriched the Church's own social ethics. After that prime, in a more complex society, chivalry lost its central place, but its derivatives spread out in forms sometimes scarcely recognizable, such as the regimental tradition in regular armies, the punctilios of duellists and some of the rules of the professions themselves. All these became components of the ethos of western society. That can be proved from observable historical facts, and the facts of professional history may be used in the same way. They illuminate the unending action and reaction, sometimes friction and sometimes mutual reinforcement, between the organized professions and those other organizations, more or less adequately representing the interests of society as a whole, which we group together under the names of public opinion and the state.

Social organization exists in the first place to allocate functions among individuals and groups of men so that the work of society may be done by those who are available or may be made available. Once this is effected we have machinery capable not only of carrying out specific tasks, but of bringing minds and energies to bear on the collective mind and action of society. In the medical sphere, that is, the professional organization is the bridge between the millions of decisions and the final ethos or policy. The history of the medical professions builds one of the bridges between the history of thought and the history of civilization.

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In 1919, the year of the Treaties of Versailles, Sir Ernest Rutherford moved from Manchester to Cambridge to continue his work on nuclear physics as head of the Cavendish Laboratory. Soon after he arrived he asked a Cambridge historian why it was that historians did not unite for combined research into selected, cardinal problems as the scientists did, but, with few exceptions, worked as isolated individuals, each following his own trail from one discovery to the next. The historian explained the British tradition of research and education in the arts subjects. I believe he said that the freedom of original thought would be impaired if the leading authorities were to prescribe subjects and methods to their juniors, and that the synthesis of their results was made not in a co-ordinating organization but through each historian's own reading and thinking.

Since the date of that conversation historians have widened their experience of co-operation in a good many promising ways. Those of us who are concerned with medical history are amongst the most fortunate in this respect. We are provided with special libraries and bibliographies, and with well-coordinated societies and conferences. It is proper that on this occasion I should mention the Wellcome Trustees who have furthered this co-operation at many points by their well-directed munificence. It is proper that I should also mention the generosity of all the workers in this field in making their knowledge available for common use. But the contrast between the dispersion of historical studies and the concentration of science remains. Nuclear physicists have transformed our worlds. In 1945, the year of Hiroshima, Sir Llewellyn Woodward, a distinguished historian and a specialist in this matter, published a lecture entitled *Some Political Consequences of the Atom Bomb*. He said: 'We know the occasions out of which wars have arisen but . . . we can make very few generalisations about the causes of war [and] we are in the dark about the value of any political arrangements that we may make for security.' The lecture contained a plea, still alas unheeded, for an immediate inquiry into war as 'one of the main social activities of man'. Another of these main social activities is organized work for healing the sick and injured and for preserving health. The histories of these two activities are complementary parts of a greater whole. Perhaps you will agree that the history of the medical profession is something far different from an antiquarian relaxation.