Article

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S.E.D. Shortt

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MEDICAL PROFESSIONALIZATION: PITFALLS AND PROMISE IN THE HISTORIOGRAPHY

S.E.D. Shortt*

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Stephen Leacock once suggested that the befuddled and shabby appearance of the academic revealed a mind 'defective and damaged by education.'[1] His pessimistic description might well apply to the effects visited upon the historian who attempts a review of the literature on professionalization. As Harold Perkin has recently observed, the professions have inspired little more than 'house histories of professional bodies,'[2] a genre which Charles Rosenberg suggests is 'so thin and lacking in critical framework as to be of almost no use to succeeding scholars.'[3] Faced with the analytical vacuum in existing historiography, the historian may turn to the work of sociological colleagues. To the uninitiated, the works encountered present both a taxonomic quagmire and a series of theoretical constructs quite at odds with the historian's principal concerns. As one exasperated historian has lamented, 'imposing a definition [of professionalization] coined by a 20th-century sociologist interested in the cosmetic industry' will produce 'nonsensical results' when applied to the nineteenth-century. Scientists such as Charles Lyell, John Herschel or Charles Darwin, for instance, all lacked both the specialized training and the income derived from the sale of that expertise now used as standards by which to define professionals.[4] Nor do definitions derived from present practice take into account vestigial criteria -- 'character,' for example -- once deemed essential to professional status.[5] It is no surprise, then, that another historian of science has recently warned his colleagues that they 'simply cannot use the definitions of professionalism that appear in most of the current sociological literature.'[6] As will be clear from works referred to below, sociology is an admirable source of insight and methodological innovation: it is not, however, the final arbiter of conceptualization or definition.

The first pitfall encountered by the historian, then, is in deriving a workable definition of professionalization. Given the obscurity or confusion in the existing literature, it seems wise to accept the judgment of a recent student of Victorian science who suggests that leaving the term deliberately vague 'is not a bad procedure.'[7] As Thomas Haskell has suggested, 'our inability to agree on an exact line of demarcation between amateur and professional, or profession

* Queen's University

and non-profession, does not make these categories themselves unintelligible.'[8] For the present, then, medical professionalization may simply be said to denote a process by which a heterogeneous collection of individuals is gradually recognized, by both themselves and other members of society, to constitute a relatively homogeneous and distinct occupational group.[9]

Academic masochists may well wish to drop out at this point to pursue endless refinements of this imprecise definition. For those content to live with a measure of conceptual uncertainty, four general areas may be identified as particularly germane to current historiography. First, is it productive to view the medical profession as a monolithic structure or must the historian isolate within this grouping significant subdivisions for closer scrutiny? Secondly, is it appropriate to assume an intimate correlation between alterations in medical practice and the process of professionalization? Thirdly, does a growing corpus of medical knowledge necessarily suggest an increase in the aggregate status of physicians?[9] Finally, to what degree do external factors unrelated to the internal dynamics of the profession mold and shape its collective character? The following paragraphs suggest responses to these issues found in recent historiography.

A potentially serious pitfall in the use of the professionalization concept is to apply it without qualification to all individuals engaged in the practice of medicine. In fact, medical practice represents a spectrum of individuals, from the rural general practitioner to the university-affiliated specialist, whose interests often vary and, occasionally, conflict. The sociologist Ivan Waddington, for example, has recently suggested that the first half of the nineteenth century witnessed a dramatic transformation in the organization of British medicine. In non-metropolitan areas, the traditional divisions between apothecaries, surgeons and physicians became blurred and indistinct as a burgeoning, affluent middle-class demanded attendance from physicians willing to practice a composite style of medicine. The professional activities, economic status and social position of the nascent general practitioners seem quite different from those of the members of the ancient corporations who continued to limit their practice to a particular branch of medicine.[10] The latter were found largely in London, maintained close ties with the Royal Colleges, and usually held hospital and teaching appointments. As Jeanne Peterson has suggested in her study of these consultants, their professional deportment depended less on the service demands of the patients, than on personal relationships among themselves and with the lay boards of governors who controlled the crucial hospital appointments.[11] This divergence of interest between general practitioners and consultants became obvious on many occasions throughout the century, most notably with the founding of the British Medical Association in 1856 and the passage of the Medical Registration Act of 1858.[12] Nor was this type of conflict confined to Britain. Mid-century

American general practitioners, already threatened by competition from sectarians and convinced that medical schools produced a surfeit of graduates, were clearly hostile to hospital consultants and their free dispensaries.[13] To a somewhat later generation of community practitioners, it was the single-purpose clinics concerned with such matters as neonatal care, tuberculosis or vaccination which fueled their opposition to public health specialists and consultants in fields such as bacteriology.[14] Similarly, divisions have recently been suggested between urban and rural practitioners in Lower Canada during the 1840s and Ontario over the final quarter of the century.[15] From such evidence it seems clear that the medical profession, despite increasing homogeneity, was not a monolithic structure; rather, it was composed of diverse and often competing subgroups for whom the professionalization process had significantly different patterns and meaning.

By way of caution, it should be conceded that an overemphasis on the diversity of the profession might well lead to a new pitfall through the creation of artificial distinctions. According to Mary Roth Walsh, for example, it is inaccurate to view the flood of regulations concerning late nineteenth-century licensure and medical education as a barrier designed to isolate and exclude women practitioners. In fact, with criteria for admission to the profession now visible and concise, their entry was possibly fascilitated.[16] And once entry was secured, the pattern of professional behaviour may have differed little from that of male counterparts. A comparative study of obstetrical practices amongst male and female physicians in Boston in the final decades of the nineteenth century was unable to demonstrate any significant difference between the two groups in terms of medical theory, daily practice, or therapeutic consequences.[17] In many respects female practitioners may have differed from male physicians, but our present knowledge of their response to professionalization does not serve to distinguish between them.

Some years ago Erwin Akerknecht brought to the attention of his colleagues another significant pitfall in the literature on medical professionalization. In arguing for what he termed a 'behaviourist approach' to medical history, he observed that it was misleading to assume a direct correlation between medical theory and medical practice. By way of example he cited the case of surgical anaesthesia, a procedure introduced into clinical practice during the 1840s, but apparently absent thirty years later in the field surgery of the Franco-Prussian War.[18] This point sheds disconcerting light on the assertion of an American sociologist, William Rothstein, that medical professionalization can in large part be attributed to an increase in what he terms 'valid' therapy, that is, therapies possessing 'a high degree of therapeutic value with practically no side effects.'[19] In fact, there is substantial evidence to suggest that physicians ignored the most 'valid' of therapies and did rather well with treatment modalities now considered not only ineffectual but actually harmful. In England, for

example, it seems that only in the 1880s, after fifteen years of fierce debate, did English surgeons adopt the method, if not the theory, of Lister's antisepsis.[20] If such reticence was evident in the relatively sophisticated surgical centres of Great Britain, it is doubtful that Canadian practitioners were any more innovative in their techniques. It is difficult, then, to argue that professionalization was causally linked to a procedure certainly valid, but only sporadically endorsed. Moreover, the very issue of valid therapy is misconstrued. As Charles Rosenberg has recently argued, the efficacy of a treatment was interpreted by the nineteenth-century patient largely in terms of its physiological activity, its ability, for example, to 'regulate the secretions.' Such ability was surely possessed by the infamous calomel and, indeed, by most other forms of 'heroic' therapy. Treatment, however dubious, reassured to the degree that it demonstrably acted and in the process, may well have enhanced the professional stature of its purveyor, the physician.[21] It is, then, unwise to regard the development of valid therapeutics as a reliable index of advances in the collective status of physicians.

If such is the case for medical therapy, it is hardly surprising that attempts to correlate professionalization with developments in medical theory provide an even greater pitfall. It is an implicit assumption of traditional medical historiography that the so-called 'rise of modern medicine' can be directly linked to advances in biomedical science. Certainly, it is undeniable that the nineteenth century saw the accumulation of a substantial body of new medical knowledge. In a five-year period between 1879 and 1884, to cite one example, the causative agent was discovered for numerous infective diseases including tuberculosis, diphtheria, cholera and typhoid.

Beneficial as these discoveries would eventually become, with the exception of the use of diphtheria anti-toxin in the 1890s, none of them were directly relevant to patient care; as such, their ability to enhance medical prestige remains problematic. Indeed, if further study is required of the linkage between what hindsight allows historians to label as 'true' science and professionalization, the same attention must be accorded to so-called 'pseudo-science.' A case in point is phrenology. Now dismissed as a fanciful theory of cranial bumps, in its heyday it informed the neurological thought of many of Britain's leading psychiatrists.[22] To a layman in the 1830s, no standard existed by which one could dismiss such individuals as quacks, in preference to those who supported the type of cerebral localization which would later guide the works of Paul Broca or Hughlings Jackson. To assume, then, on the one had, a direct correlation between biomedical discovery and the status of physicians, and on the other, to dismiss 'pseudo-science' as non-contributory, constitutes a significant impediment to an understanding of professionalization.

A final pitfall in dealing with the professionalization of

medicine is the tendency to ascribe changes in the status of physicians largely to the internal dynamics of the profession without appropriate reference to the society in which those changes occurred. Since the same difficulty has been confronted in the history of science, it may be appropriate to begin by reference to a recent revisionist article by Arnold Thackray. The emergence of organized science in the nineteenth century, he argues, cannot be explained simply by the technological demands of industrialization. Rather, a more fruitful explanation may lie in the changing cultural context of natural knowledge. The eighteenth-century perception of science as an appropriately genteel pursuit for aristocratic diletantes was transformed by 1840 into an integral component in the value system of the entrepreneurial middle class. The instruments of this transformation were newly-prosperous inhabitants of provincial towns, a group cut off from the traditional rewards of English society by their commercial occupations, dissenting religions and limited political force. Science, for these individuals, became a particularly appropriate 'mode of cultural self-expression,' a means of revealing their commitment to learning, to the theological implications of nature, and to a useful form of entertainment. More significantly, the pursuit of natural knowledge served to announce 'their distance from the traditional value system of English society, and offered a coherent explanatory scheme for the unprecedented, change-oriented society in which they found themselves.' In this sense, the espousal of science had little or nothing to do with either its factual content or practical application. Borrowing terminology from the Chicago School of Sociology popular during the 1930s, Thackray concludes that the pursuit of science became the means by which socially-marginal individuals sought their own legitimation.

A significant proportion of the individuals in Thackray's Manchester-based study were physicians. Ian Inkster has more recently adopted this approach specifically as a method of studying the professionalization of the Sheffield medical community. In the early nineteenth century, these doctors were 'marginal twice over, for they were both provincials striving for individual status, and members of a profession yet in the making.' Nineteen separate licensing bodies conferred certification as late as 1858 such that 'laymen could not immediately identify the status of any one medical man,' nor could these physicians readily 'gain the sanction of the community.' The opening of the Sheffield Infirmary (1794) provided them with an opportunity to participate in charitable work as an affirmation of benevolent respectability. More significantly, the Society for Literary Conversation (1806), with its frequent medical discussions, permitted the incorporation of scientific discourse into the range of interest encompassed by polite learning. The social contacts accumulated through such institutional affiliations, buttressed by shared religious and political perspectives, conferred on medical men a degree of 'social comfort' by the 1840s.[24] In effect, the professionalization of the Sheffield medical community occurred without reference

to the technical competence, theoretical assumptions or organizational structure of the profession. Only recently have Canadian historians accorded similar attention to extra-medical factors in their assessment of professionalization,[25] suggesting that a neglect of the cultural context of professionalization remains a serious pitfall.

The history of the medical profession in Canada, in fact, has yet to be approached in a synthetic fashion in works comparable to those by Rothstein or Peterson. The existing literature is, at best, fragmentary, and tends to focus on discrete aspects of professional evolution in the nineteenth and early twentieth centuries. The legal provisions under which Ontario physicians functioned have been described, but no extensive analysis of their derivation or implications has been undertaken.[26] The growth and structure of medical societies has been chronicled, usually in a commemorative fashion, but the social role of these groups or the manner in which, for example, their collective weight was turned to economic or political objectives remains unclear.[27] Medical journals, the proliferation of which is often assumed to be a hallmark of professional maturity, have been catalogued, but their role in disseminating medical knowledge or in creating an effective political identity is still obscure.[28] Only the superstructure of medical education has been studied, leaving the most significant questions unanswered.[29] How did professors attain their positions and from what motives? How were students recruited and from what social class? Did this change over time and, if so, for what reasons? What subjects were taught and from what textbooks? Even with a more comprehensive knowledge, however, of the institutional superstructure of the profession, of its laws, societies, journals and schools, the central problem will only have been touched in a superficial fashion. A profession is a social creation and meaningful only in terms of its social context and function. Did sectarian practitioners hasten or hinder professionalization? What influence did developments in other fields such as law or engineering have on medicine? Did specific diseases such as cholera advance or detract from the status aspirations of physicians? It is the study of such broader aspects of organized medicine which constitutes the most fruitful approach to the professionalization process.

This brief paper has assumed, as an act of faith, that professionalization is a useful historical tool. It has attempted to outline the major pitfalls to which its utilization appears prone and has suggested means of avoiding these obstacles found in recent literature. It seems clear that ahistorical definitions coined by other disciplines are best avoided. To assume that professionalization held the same meaning for all physicians practising in a given time or place tends to obscure significant intra-professional variations. Innovations in biomedical theory or medical therapeutics do not necessarily correlate with advancing professional status, any more than the espousal of 'invalid' therapies or 'pseudo-scientific' concepts mitigate against the

attainment of such stature. Finally, professionalization is a process which occurs within a specific cultural context, a context which must be analyzed if the process itself is to be made comprehensible. Canadian historians are fortunate to find themselves relatively unencumbered by a weighty but unsophisticated historiography.[30] An awareness of the pitfalls in previous literature and of the promise of more discriminating recent studies augers well for the historiography of Canadian medical professionalization.

NOTES

1. Stephen Leacock, 'The Apology of a Professor,' *University Magazine* IX: 4 (1910), 176.

2. Harold Perkin, 'Social History in Britain,' *Journal of Social History* 10:2 (1976), 141.

3. Charles Rosenberg, 'The Medical Profession, Medical Practice and the History of Medicine,' in Edwin Clarke, ed., *Modern Methods in the History of Medicine* (London, 1971), 27.

4. S.F. Cannon, *Science in Culture: The Early Victorian Period* (New York, 1978), 171, 142-3.

5. Burton Bledstein, *The Culture of Professionalism: The Middle Class and the Development of Higher Education in America* (New York, 1976), chapter 4.

6. Nathan Reingold, 'Definitions and Speculations: The Professionalization of Science in America in the Nineteenth Century,' in A. Oleson and S.C. Brown, eds., *The Pursuit of Knowledge in the Early American Republic: American Scientific and Learned Societies from Colonial Times to the Civil War* (Baltimore and London, 1976), 37. As will be noted, many important works on the history of medical professionalization are by sociologists (Waddington, Rothstein, Parry) or heavily influenced by their work (Peterson, Thackray, Inkster).

7. Cannon, *op. cit.*, note 4, 171.

8. Thomas L. Haskell, 'Are Professors Professional?' *Journal of Social History* 14:3 (1981), 490.

9. A useful framework for studying this transition is George Daniels, 'The Process of Professionalization in American Science: The Emergent Period, 1820-1860,' *Isis* 58 (1967), 151-66.

10. Ivan Waddington, 'General Practitioners and Consultants in Early Nineteenth-Century England: The Sociology of an Intra-Professional Conflict,' in J. Woodward and D. Richards, eds., *Health Care and Popular Medicine in Nineteenth-Century England: Essays in the Social History of Medicine* (London, 1977), 164-88.

11. M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley and London, 1978), 123-4, 141.

12. These conflicts are described in Noel Parry and Jose Parry, *The Rise of the Medical Profession: A Study in Collective Social Mobility* (London, 1977), 104-61.

13. Charles Rosenberg, 'Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary,' *Journal of the History of Medicine and Allied Sciences* 29:1 (1974), 51.

14. Barbara Rosenkrantz, 'Cart before the Horse: Theory, Practice and Professional Image in American Public Health, 1870-1920,' *Journal of the History of Medicine and Allied Science* 29:1 (1974), 65,68-71; John Duffy, 'The American Medical Profession and Public Health: From Support to Ambivalence,' *Bulletin of the History of Medicine* 53:1 (1979), 8, 10, 16. See, also, Stephen Novak, 'Professionalism and Bureaucracy: English Doctors and the Victorian Public Health Administration,' *Journal of Social History* 10:4 (1973), 440-62.

15. Papers presented to the American Association for the History of Medicine, Toronto, May, 1981: Jacques Bernier, 'The Origins of the Collège des Médicins et Chirurgiens du Québec: A Reevaluation'; Daniel McCaughey, 'The Overcrowding of the Profession: Ontario, 1870-1914.'

16. Mary Roth Walsh, *"Doctors Wanted, No Women Need Apply": Sexual Barriers in the Medical Profession, 1835-1975* (New Haven and London, 1977), 10-15.

17. Regina Morantz and Sue Zschoche, 'Professionalism, Feminism and Gender Roles: A Comparative Study of Nineteenth-Century Medical Therapeutics,' *Journal of American History* 67:3 (1980), 568-88.

18. Erwin Ackerknecht, 'A Plea for a "Behaviourist" Approach in Writing the History of Medicine,' *Journal of the History of Medicine and Allied Sciences* 22:3 (1967), 211-14.

19. William Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science* (Baltimore and London, 1972), 4, 9-10.

20. A.J. Youngston, *The Scientific Revolution in Victorian Medicine* (London, 1979), especially chapters 3 and 5.

21. Charles Rosenberg, 'The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America,' in Morris J. Vogel and Charles E. Rosenberg, *The Therapeutic Revolution: Essays in the Social History of American Medicine* (Philadelphia, 1979), 3-25.

22. R.J. Cooter, 'Phrenology and British Alienists, c. 1825-1845, Part I: Converts to a Doctrine,' *Medical History* 20:1 (1976), 1-21 and 'Part II: Doctrines and Practice' *ibid.*, 20:2 (1976), 135-51.

23. Arnold Thackray, 'Natural Knowledge in Cultural Context: The Manchester Model,' *American Historical Review* 79:3 (1974), 672-709. See, also, Steven Shapin and Arnold Thackray, 'Prosopography as a Research Tool in History of Science: The British Scientific Community, 1700-1900,' *History of Science* 12 (1974), 1-28, and Morris Berman, *Social Change and Scientific Organization: The Royal Institution, 1799-1844* (Ithaca, 1978).

24. Ian Inkster, 'Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield, 1790-1850,' in Woodward and Richards, *op. cit.*, note 10, 128; 131, 140-43, 149.

25. S.P. Kutcher, 'Toronto's Metaphysicians: The Social Gospel and Medical Professionalization in Victorian Toronto,' *HSTC Bulletin* 5:1 (1981), 41-51.

26. Elizabeth McNab, *A Legal History of the Health Professions in Ontario: A Study for the Committee on the Healing Arts* (Toronto, 1970). Note, also, Barbara Tunis, 'Medical Licensing in Lower Canada: The Dispute Over Canada's First Medical Degree,' *Canadian Historical Review* 55:4 (1974), 489-504.

27. H.E. MacDermot, *History of the Canadian Medical Association, 1867-1956*, 2 vols. (Toronto, 1935, 1958); John Ferguson, *History of the Ontario Medical Association, 1880-1930* (Toronto, 1930); Glenn Sawyer, *The First 100 Years: A History of the Ontario Medical Association* (Toronto, n.d.).

28. H.E. MacDermot, *A Bibliography of Canadian Medical Periodicals, With Annotations* (Montreal, 1934); C.G. Roland and Paul Potter, *An Annotated Bibliography of Canadian Medical Periodicals* (Toronto, 1979). The only analytic study of medical journalism is C.G. Roland, 'Ontario Medical Periodicals as Mirrors of Change,' *Ontario History* 72:1 (1980), 3-15.

29. G.W. Spragge, 'The Trinity Medical School,' *Ontario History* 58:2 (1966), 63-99; C.M. Godfrey, 'The Origins of Medical Education of Women in Ontario,' *Medical History* 17:1 (1973), 89-94; Robert B. Kerr, *History of the Medical Council of Canada* (Ottawa, 1979); H.E. MacDermot, *Sir Thomas Roddick* (Toronto, 1938); D.S. Lewis, *The Royal College of Physicians and Surgeons of Canada, 1920-1960* (Montreal, 1962); A.W. Andison and J.G. Robichon, *The Royal College of Physicians and Surgeons of Canada* (Ste. Anne de Bellevue, 1979).

30. There is, however, a rapidly expanding interest in Canadian medical professionalization. For example, see

the papers by Bernier and McCaughey, note 15, and Kutcher, note 25, above. Other contributions include: R.D. Gidney and W.P.J. Miller, 'The Politics of Medical Professionalization, Upper Canada, 1850-1869,' paper presented to the Workshop on Professionals and Professionalization, University of Western Ontario, March, 1981; a series of three papers presented to the Canadian Society for the History of Medicine, Halifax, June, 1981: C.G. Roland, 'The Canadian Medical Journal: Communication of Medical Information in 19th-Century Canada,' Barbara Tunis, 'Lower Canada: Professionalization of Medicine, 1788-1840,' and Colin Howell, 'Professionalization and the Progressive Reform Impulse: Reform, Professionalism and the Medical Profession in Maritime Canada, 1880-1914;' Barbara Tunis, 'Medical Education and Medical Licensing in Lower Canada: Demographic Factors, Conflict and Social Change,' *Histoire Sociale/Social History*, No. 27 (1981), 67-91; Colin Howell, 'Professionalism, Reform, and the Monopolistic Impulse: The Professionalization of Medicine in Maritime Canada, 1880-1910,' *Acadiensis* (forthcoming).