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MEDICAL KNOWLEDGE AND THE PATRONAGE SYSTEM IN 18th CENTURY ENGLAND*

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Abstract Medical knowledge in eighteenth century England was characterized by the growth of numerous often contradictory theoretical systems, founded upon a common underlying analogy of bodily processes. This foundation of metaphor was derived from the ancient humoural model of classical medicine, attenuated by the introduction of concepts imported from contemporary mechanical philosophy. Medical theory may be viewed as a form of social interaction between physicians—the elite of the eighteenth century profession—and their aristocratic patients. The phenomenological conceptualization of disease, the speculative and systematic character of pathology, the psychosomatic interpretation of illness and the swingeing use of heroic therapies may be ascribed to the predominance of the upper class patient in the consultative relationship. Furthermore the contemporary career system constrained physicians both to establish their credentials as members of the upper class and to advertise their services by individual display. Fashion provided a form of social behaviour which reconciled these demands, but also generated a profusion of medical theories. In addition the structure of relationships between patients and practitioners, and among medical men themselves, prohibited the emergence of a scientific community dedicated to the analysis of medical problems.

1. *Introduction*

It is the object of this paper to construct a sociological explanation of the origins and nature of medical beliefs in 18th century England.[1] It will be argued that the distinctive characteristics of contemporary theories and therapies were shaped by the constraints acting upon the process of medical innovation generated within the structure of relationships between patients and practitioners. Medical knowledge will be located in the context of this configuration, and thus will be viewed as a form of social interaction between the sick and medical personnel.

The period under consideration began with the changes in the English class structure of the mid-17th century, and ended with the rise of an industrial bourgeoisie in the decades after 1780. The analysis will commence with a brief outline of the major features of the corpus of medical knowledge in this era, In particular attention will be directed to the symptomatic definition of disease, and the systemic, monistic, and psychosomatic theories of speculative pathology

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which dominated medical thought. This will be followed by an examination of the dynamics of the consultative relationship. The key feature of this relationship will be identified as the dependence of the elite of the medical profession upon the fees and favours of their aristocratic patients. Through the patronage system the sick were able to exercise control over the course of medical innovation. Hence the form and contents of medical theories reflected the assumptions, obsessions, and interests of the most powerful section of the lay public. The manner and consequences of the permeation of the upper class patient's definition of the situation into medical theory and practice will be examined in detail. The paper then moves on to consider more closely the impact of the career system upon the organization of medical beliefs. It will be seen that, in the absence of academic or professional criteria, patients recruited their practitioners by means of personal selection in the context of primary social interaction. Thus physicians were enjoined to adopt the stereo-typed lifestyle of their genteel clients whilst simultaneously advertising their services by means of individual display. This peculiar amalgam of social conformity and personal eccentricity, when translated into intellectual activity, led to the creation of a profusion of competing theories which, despite their mutual hostility, shared a number of implicit paradigmatic assumptions. Finally some of the obstacles to the development of scientific medicine in 18th century England will be discussed. Reference will be made to the popular distaste for experimental and scientific study of physiology and anatomy. It will also be argued that the network of relationships among medical investigators themselves seriously inhibited the formation of a community of scientific research workers dedicated to the analysis of medical problems.

2. *The Corpus of Medical Knowledge*

In the period under consideration medicine was regarded as an area of intellectual enquiry in its own right.[2] The 17th century scientific revolution had little impact on the fundamental characteristics of theory and therapy.[3] Furthermore included within the rubric of medicine was a wide range of subjects which have since grown into autonomous disciplines, such as chemistry and botany. Contemporary medical investigators pursued two major courses. Firstly there was the elaboration of taxonomies of illness, or nosologies, which upon examination turn out to be classifications of symptom complexes rather than disease entities. Secondly there was a prolific growth of monistic and speculative systems of pathology, often in bitter dispute with one another. These systems were invariably accompanied by recommendations for the stringent use of heroic remedies.[4]

One of the most important characteristics of 18th century medical thought was the significance that was attached to the analysis of symptoms and the relative lack of interest shown in the actiology of disease. The very definition of illness

was couched in terms of the patient's complaint, rather than internal lesions or cellular malfunctions. Sydenham suggested that man was capable 'to perceive only the superficies of bodies, not the minute processes in nature's "abyss of cause".'[5] He recommended that diseases should be classified according to their external characteristics, like plants. In this way he hoped to build up a kind of natural history of disease derived from phenomena directly available to sensation unaided by instruments. This approach to nosology was adopted by most medical investigators, with some minor modifications, until the early 19th century.[6] Consequently nosography became a chaotic compendium of syndromes extrapolated from the patient's subjective experience of 'feeling poorly'. Eighteenth century taxonomies elaborated a quite specious series of diseases, whilst failing to differentiate between illnesses which happen to have similar or interconnected symptoms.

Perhaps the most immediately striking feature of 18th century pathology was the general lack of agreement about the causes of illness and the effectiveness of therapies. Medical knowledge consisted of a chaotic diversity of schools of thought, each strenuously seeking to attain ascendency over the others. Despite the plethora of shifting viewpoints, however, a closer examination reveals that the 18th century systems of pathology were based upon a common set of assumptions about the nature of health and disease. These assumptions formed the analogue, or foundation of metaphor, upon which the innumerable alternative theories were raised. The premises of 18th century medicine were derived from the humoural model of bodily processes, originally developed in the works of Hippocrates and Galen.[7] The Hippocratic texts regarded illness not as a localized or specific event but as a general disturbance of the organism. The human constitution was formed from four humours: blood, phlegm, yellow and black bile. Normal health consisted of a stable balance of these humours in proportions appropriate to the age and personality of each individual. Illness was conceptualized as a disturbance of this equilibrium. The theories of the Hippocratic school were developed in the second century A.D. by Galen, physician to the Emperor Marcus Aurelius, who produced an elaborate system of medicine based on the humoural principle.

The medical beliefs of the classical authors enjoyed great authority in 15th and 16th century Europe. However during the revolutionary upheavals in English society of the mid 17th century the ideas of Hippocrates and Galen came under attack from a number of quarters. One particularly powerful influence upon the development of medical knowledge during this period was that of Newtonian physics. The mechanical philosophy enjoyed remarkable prestige in both scientific and non-scientific circles. The elite of the medical profession accordingly sought to import its fashionable notions into their theories. Most of the medical authors who invoked the name of Newton had little but the vaguest comprehension of his theories. Furthermore a number of different interpretations of his ideas were in circulation.[8] Hence the introduction of Newtonianism into medicine

did not herald a thoroughgoing reformulation of theories of pathology. Instead it gave a new lease of life to the ancient conceptions of disease which reappeared under a new guise. The basic entities of the humoural system were re-defined in terms of material entities, such as corpuscular flow or excitement of the muscles, but the general conception of the bodily system propounded by Hippocrates and Galen remained the guiding principle of research and practice. Thus, despite criticism of specific aspects of the ancient texts and the appeal to new sources of legitimation, the classical authors remained the standard works read by medical students at the English universities. In short the conceptual foundations of classical medicine were refined and consolidated by the accommodation of a crude Newtonianism.

What were the major features of 18th century theories of pathology? Firstly contemporary concepts of disease did not employ the modern notion of illness as a localized physiological or anatomical event. Instead, as already indicated, health was conceptualized in terms of the overall condition of the constitution. Pathology was systemic rather than organic or cellular. Furthermore, although the various theories were frequently in dispute over the precise cause of illness, typically they subscribed to the belief that disease resulted from one underlying state of the body. In other words 18th century pathology was monistic in form, constructed upon a single explanatory principle. Thus, rather than search for the proximate causes of particular illnesses, medical theorists preferred to look for a single underlying condition of which the various specific diseases were but examples. Although pathology was reduced to a single grand design, however, any par icular case of illness was regarded as the product of individual circumstances and situations. Each man suffered from his own peculiar combination of factors which accounted for his physiological disequilibrium. Although there was only one pathological condition there were innumerable pathological careers. Thus contemporary systems of pathology provided a complete explanatory scheme capable of accounting for each and every ailment afflicting mankind, whilst at the same time institutionalizing an individualistic conception of illness which recognized each case to be a unique configuration of bodily disorders. Universalistic theory was reconciled with particularistic therapy.

Another remarkable feature of 18th century theories of pathology was the absence of a sharp distinction between afflictions of the mind and of the body.[9] Emotional temperament and physical disposition were believed to be closely related, and considerable attention was paid to the patient's subjective impressions of his disease and its cure. The interest shown by contemporary practitioners in conditions such as hypochondriasis illustrates the close association believed to exist between psychological disorders and somatic events.[10] There is no exact equivalent of hypochondriasis in modern medicine, but in the 18th century it was regarded as a real and serious condition with its seat in the upper abdomen. Hypochondriasis involved physical and spiritual pain and could be induced either

mentally or physically. Particularly prevalent among the fashionable and cultivated, it appears to have been some kind of physiological manifestation of ennui.

The continual and often bitter controversy between adherents of rival medical systems was not conducted according to the canons of scientific method. The authors of 18th century medical theories derived their ideas from metaphysical speculation upon the ultimate nature of human life and scorned experimental science. The proponents of each school advanced unsubstantiated and grossly exaggerated claims of success, accompanied by libellous denunciations and vilifications of the work of other investigators. Much of this conflict revolved around the relative efficacy of the various materia medica and other remedies which each system championed. The medical systems accorded the physician a decisive role in maintaining the health of his patient. The restoration of the sick man's physiological equilibrium was to be achieved by means of a heavy application of a wide range of heroic remedies and exotic potions. Medical men were also responsible for an impressive array of infernal machines, such as the ghastly stomach brush or the more intriguing celestial bed which guaranteed its occupants sound sleep, divine orgasms, or beautiful children as required. These panaceas were extravagantly employed upon those members of the public unfortunate enough to afford their exorbitant cost, whilst their inventors advertised wildly exaggerated accounts of their powers.

3. *Medical Knowledge and the Consultative Relationship*

It is the thesis of this paper that the distinctive characteristics of 18th century medical knowledge were formed by the constraints placed upon medical innovation within the structure of social relationships between patients and practitioners. The dynamics of this relationship may only be understood in the light of a brief analysis of the general system of social stratification of 'Augustan' England.[11]

In the first half of the 18th century English society may be described as a complex hierarchy of wealth and prestige converging at the top onto a tiny group of rich and powerful landowners. Perkin describes English society on the eve of the industrial revolution as 'a finely graded hierarchy of great subtlety and discrimination in which men were acutely aware of their exact location to those immediately above and below them, but only vaguely curious except at the very top of their connections with those at their own level.'[12] The political, economic, and cultural hegemony of the nobility and aristocracy was overwhelming. Deference to superiors was part of the unquestioned fabric of social life into which Englishmen were born and raised. The distinctions of status were everywhere proclaimed and respected in the stereotyped rituals of speech, manners, deportment, livery, architecture, taste, and innumerable other cultural symbols. The major horizontal cleavage in this hierarchical system of stratification was that which separated gentlemen from the common people. The precise point of

demarcation of the upper class from the rest of the population was not simply defined however. Ideally a gentleman derived his fortune from his landed estates, though he might be engaged in certain other occupations. The distinction seems to have been made in terms of birth, manners, display and social acceptance. It was his effortless and elegant lifestyle that all classes of society recognized as the mark of a gentleman.[13]

Where did medical men fit into this hierarchy? In all the professions a line was decisively drawn between the upper ranks of practitioners who were accorded the status of gentlemen, and those who occupied the lower positions. The gulf between gentlemen and the rest was not the only professional division in the medical world of the 18th century however. Medical practitioners did not comprise an homogeneous occupational group but were divided into several, often warring, factions. The three major groups Holloway has described as the 'medical estates'.[14] Physicians, surgeons, and apothecaries each had distinctive patterns of recruitment, training, occupational associations, skills, patients, and statuses. Physicians were the most powerful, prestigious and wealthy of the three, and constituted a tiny elite among practitioners. They attended the upper classes, and had themselves received the education of a gentleman. Physicians eschewed the manual labour of surgery and pharmacy, which they regarded as beneath their professional dignity. A medical degree from one of the English universities was an essential qualification for membership of the Royal College. The costs of this academic training were high, and kept all but the wealthy out of this section of the profession.[15] Professional education at Oxford and Cambridge consisted of a six years' course in a wide range of subjects, followed by a slightly longer period devoted to a literary study of the classical medical authors.[16] Thus above all else an academic background ensured that those entering upon the practice of physic were scholars and gentlemen. By their deportment, manners, and attire physicians assiduously sought to maintain this standing in their professional lives.

The surgeon and apothecary had a lower status and income than the physician. The surgeon was irredeemably associated with manual work, and until 1745 was joined in one company with the barbers. His professional domain consisted of all those parts of the body which could be reached with a scalpel. The apothecaries were originally compounders and dispensers of drugs and bore the stigma of trade. In the 17th century however they rapidly increased in numbers and prestige, and began to change their professional function. This brought them into conflict with the entrenched powers of the Royal College of Physicians.[17] After the Rose Case of 1703 apothecaries had the legal right to attend and prescribe, but only to charge for the drugs they supplied. Henceforth apothecaries regularly attended the sick, calling in a physician in serious cases or consulting him to receive advice in one of the 18th century coffee shops. They were by far the most numerous section of the profession, and varied greatly in the character and quality of their practice. In addition to the medical estates, there were also innumerable

quacks, empirics and amateur practitioners who were an important source of therapy for all classes of the population.

Throughout the 18th century the Fellows of the Royal College of Physicians maintained their supremacy over this disparate array of practitioners, though not without pressures from below. The physicians enjoyed a number of institutional and legal powers over other sections of the profession, such as the right to inspect the drugs in apothecaries' shops. However their greatest strength lay in their close association with, and membership of, the ruling class of gentlemen. Thus, for example, by means of their personal recommendations to their upper class clientele, physicians enjoyed a considerable degree of control over the access of the lower orders of the profession to rich and influential patients. Furthermore it was in general unlikely that the upper class would permit the decay of an occupation which provided many of its sons with a lucrative and honourable position in society.[18] The interests of the gentry and nobility and of the Royal College were one. The physicians therefore were able to exercise a relatively high degree of intra-professional control over medical innovation. The lower occupational and social standing of the other medical estates prevented them from elaborating and institutionalizing their special knowledge and distinctive skills into a systematic approach to the study of medical problems. Hence a discussion of the dominant themes in 18th century medical knowledge becomes in effect an analysis of the theories and beliefs of the physicians. The ruling elite of the medical profession, and thus the ruling ideas of medical theory, were drawn from the ruling class.

However, in spite of their genteel status and pre-eminence among medical practitioners, physicians did not occupy a place of precedence within the ranks of the upper class.[19] A major distinction was drawn between the aristocracy, who were themselves ranked according to their titles, and the gentry, who were sub-divided into Baronets, Knights, Esquires, and gentlemen. In general physicians came near the bottom of this hierarchy. Only landed gentlemen enjoyed the full admiration and honours of 18th century society. Moreover medicine was not the most prestigious or highly rewarded among the professions. Hence a physician's social advancement depended upon his acquisition of sufficient fortune to purchase an estate, or upon his ability to win the favours of a grateful nobleman. Physicians therefore were committed to the preservation of the existing social order in which they already held a substantial professional and public position. At the same time they were dependent upon the rewards of their small group of upper class patients to sustain and improve their social standing. Aristocratic patients were in a position to choose for themselves the most satisfactory or amusing practitioners from among the host of medical men who clamoured for their favours. It was the patient who judged the competence of the physician and the suitability of the therapy. The wealthy and influential threw their support behind whichever practitioner pleased them and withdrew it from those in whom they were

disappointed. Thus it was the client who held ultimate power in the consultative relationship.

Through the channels of the patronage system therefore the nobility and gentry held sway over the medical profession. This was but one part of the great system of control exercised by the mighty land owners which extended throughout English society in the 18th century, and which had a profound influence on the pattern of cultural innovation.[20] The rule of property was based upon a system of personal selection and favours among friends and kinsmen which governed the distribution of rewards in all walks of life. The wealthy and powerful thus had command over extensive networks of personal loyalty and obligation. Social order was founded upon these configurations of permanent vertical dependency between patrons and their clients. Success in a medical career, as in other occupations, depended upon the cultivation of close personal ties with members of the upper class. Furthermore this elite had a keen amateur interest in medical matters, as may be seen from the contents of contemporary magazines and journals written for the upper class.[21] Physicians had no choice but to tailor their theories and remedies to meet the expectations and requirements of their genteel clients. Upper class patients were able therefore to direct the development of medical knowledge by shifting their patronage from one group of innovators to another. So great was the influence of the nobility and gentry over the process of medical innovation that even therapies which were condemned by the regular profession, such as smallpox innoculation, could become great popular successes when adopted by high society.[22] The practice of innoculation was promoted in Britain by Lady Montague in 1722 and taken up by a number of court physicians. A considerable proportion of the medical profession opposed the idea, however, because, alleged her Ladyship, they feared that it would eliminate a valuable source of income. Nevertheless George III was persuaded to permit clinical trials on six condemned convicts. These and other experiments having proved successful, members of the royal family had their children innoculated. This set the seal of approval upon the operation and it became popular, even fashionable, among the upper classes. Once a lucrative market had been established 18th century practitioners took to the operation with relish, quickly making the originally simple procedure much more complex, expensive, and dangerous.

What effect did the predominance of upper class patients over practitioners have upon the form and content of medical knowledge in 18th century England? In order to answer this question it is necessary to examine the demands made by patients upon their practitioners, and the strategies adopted in response by medical personnel. In other words medical knowledge must be seen as a form of social interaction with the consultative relationship.

One of the most important manifestations of the patient's power over the practitioner was his ability to dictate the very definition of illness itself. In particular the patient's understandable desire to be cured of his symptoms, rather than

diagnosed of his disease, had an indelible impact on contemporary theories of nosology and pathology. Medical knowledge revolved around the problems of the prognosis and therapy of symptoms, rather than the diagnosis and analysis of diseases. Symptoms were not regarded as the secondary signs of internal pathological events, but rather as the disease itself. The attention paid by the medical profession to psychosomatic conditions such as hypochondriasis illustrates the point. When the wealthy and powerful chose to identify emotional stress with disease, practitioners accepted their definition of the situation and acted as if such maladies were real pathological entities. The symptom based nosology of the 18th century was thus a reflection of a patient dominated medical system. One consequence of this situation was that 18th century physicians carefully recorded and interpreted the symptoms of their patients but rarely if ever physically examined them. Physical examination was presaged by the modern concept of disease which consigns symptoms to the role of secondary indicators.

The influence of the upper class patient may also be seen in the high status accorded to philosophical speculation by 18th century medical theorists. In an age in which upper class education and culture were founded on classical literature the prestige attached to the works of Hippocrates and Galen is obvious. Physicians preferred to justify their potions and opinions by appeal to the ancient texts rather than by laboratory experiments. The importation of the mechanical philosophy into medicine was also a function of the predominance of the upper class patient. The Newtonian cosmology enjoyed the approval of the social elite of 18th century England. It had demonstrated the divine order that governed the universe of material objects. The virtue of such a theory, when extended to encompass the social as well as the natural world, was not lost on a ruling class that had recently emerged from the turmoil of the English Revolution. The rationally organized and hierarchically stratified system in which each object, and person, had an immutable course to run was a mataphor which demonstrated and extolled order. In medicine, as in theology, literature, and social philosophy, the analogy found a comprehending and approving audience.[23] Furthermore during the later 17th century English physicians had powerful incentives of their own to introduce some novelty into their theories.[24] The elite of the medical profession had been closely associated with the ancien régime of pre-revolutionary England. During the second half of the 17th century the Royal College sought to accommodate itself to the new political and economic order, whilst retaining the privileges it had enjoyed of old. Consequently physicians were predisposed to introduce new and popular ideas into theory and therapy. As we have seen, the importation of Newtonian theories heralded few basic conceptual changes in medical knowledge, but they did provide the physicians with a more up-to-date legitimation for the continued use of long established practices.

The strategies adopted by practitioners in their relationships with their patients influenced the development of medical knowledge in a number of other ways.

In order to justify their high fees it was necessary for medical men to present themselves to the sick not merely as aids to natural recovery, but as ones who actively intervened to change the course of nature. The patient had not merely to get better: he had to be cured. Physicians wished to be seen wrestling with the mysterious forces of life and death upon the battleground of the patient's body. They required therefore remedies which made the patient conscious of the curative powers of his practitioner and of the efforts which had been made on his behalf. Here the monistic pathology and its attendant therapies stood the 18th century practitioner in good stead. He was never at a loss to know the cause and cure of his patient's ailments, whilst the blood-curdling array of heroic remedies were nothing if not memorable to those who endured them. The rationality of 18th century therapies becomes more apparent then when seen in the light of the dramatic quality which the practitioner sought to bestow upon his healing arts.

The credence given to psychosomatic concepts of disease may also be in part explained in terms of the demands made by the sick upon their practitioners. The psychological condition of the patient was a matter of vital professional concern to the 18th century doctor. The ultimate success of a consultation depended upon the patient's personal assessment of the standard of care that he had received. The sick man's evaluation of the performance of his doctor might well be influenced by the state of his mind as well as the condition of his body. Thus failure to cure a physical complaint, or even inability to avert death, need not necessarily have proved injurious to a physician's career. Similarly the mere cessation of symptoms did not guarantee the sick man's approval. Of prime importance was whether or not the patient believed he had benefited in some way from the attendance of his physician. Hence there were rich opportunities for psychotherapists of every kind. The assessment of the patient's humour, as well as his humours, played a crucial role in therapeutic techniques and theories of pathology.

The divergent interests of upper class patients and their practitioners were reconciled in the speculative systems of pathology. These theories allowed for an endless array of ailments, defined in terms with which the patient could readily identify, whilst enabling the physician to diagnose each and every malady and display limitless ingenuity in concocting cures. In other words the medical systems of the 18th century conformed to the requirements of the aristocracy and gentry, who held ultimate control over medical practitioners, whilst affording the profession considerable autonomy in responding to the demands of their patients.[25]

4. *The Career Structure*

In order to appreciate the full influence of the patronage system upon the development of 18th century medical thought it is necessary to examine the organization of the contemporary career system more closely. The sick did not

adopt either academic qualifications or professional status as the primary criteria in the selection of their medical practitioners. Instead they sought their assurance of the therapeutic effectiveness and ethical propriety of medical personnel through the personal relationships they established with their doctors in the network of face to face relationships which made up the patronage system. Medical men acquired their occupational licence by means of primary social interaction with their patients.

The particularistic nature of the consultative relationship between upper class patients and their practitioners was reflected in the particularistic conceptions of disease current in the 18th century. The sick demanded personal attention from their doctors, and medical men for their part sought to make themselves indispensable to their clients. It has already been suggested that the monistic systems of pathology insured that physicians were never without an explanation and a cure. Equally however, because each patient was held to have his own unique configuration of bodily processes, the physician could lay claim to special insight into the individual features of the sick man's disorder. The medical systems enabled the practitioner to combine diagnostic infallability with personal service. As a result the patient rather than the disease remained the focus of theory and practice. This had a disastrous influence on the status of quantitative methods in 18th century medicine. Diagnosis was more a matter of judgement than measurement. Practitioners sought to highlight the personal experiential qualities of maladies rather than subsuming them within generalized disease categories. Thus, for example, the pulse watch, introduced by Sir John Floyer in 1707, was virtually ignored by the medical profession until the early 19th century. On the other hand an elaborate qualitative pulse lore thrived throughout the period under review.

Professional advancement in the medical world of the 18th century, then, was achieved by means of individual recruitment, through personal contacts, of a group of regular clients upon whose fees and favours the practitioner relied. To obtain a clientele of this kind it was necessary for a medical man to move in the social circles from which he hoped to draw his fees,[26] for the public were liable to assess the professional suitability of a practitioner by the status of his lifestyle. Hence above all else physicians sought to be 'in society', and to display those exquisite standards of taste, etiquette, and bearing denied the meaner sort. Such cultural artifacts as gorgeous apparel, stylish manners, and witty conversation both symbolized and legitimized their close contact with the upper class. Similarly the Royal College placed great store by attendance at the English universities, acquisition of the Latin tongue, and familiarity with classical culture because these attributes were basic requirements for acceptance into the social circles of the nobility and gentry. In short since the patient assessed the worth of his doctor in face-to-face interaction it was necessary for the physician to adopt the stereotyped manner and intellectual worldview of his upper class clientele.[27] In addition

to establishing his credentials as a gentleman, however, the ambitious physician also had to draw attention to his own special talents and skills. His career depended upon convincing a sceptical society of the superiority of his services over those of his peers. Physicians were encouraged therefore to bring themselves before the public eye by every devious method of self advertisement their prolific ingenuity could devise. The successful physician was one who succeeded in becoming part of upper class society whilst simultaneously exploiting its fads and foibles.

The career of the physician consisted therefore of a peculiar amalgam of ingratiation into the social circles of the nobility and gentry by means of conformity to the norms of upper class life, accompanied by individual struggle for recognition by means of personal display and publicity.[28] The social constraints placed upon an actor in such a situation are likely to induce him to adopt that form of social interaction described by George Simmel as fashion. Fashion is a type of behaviour in which the actor is enabled to attract attention and approval as an individual whilst at the same time asserting his membership of a particular social group or class. 'It is a peculiar characteristic of fashion that it renders possible a social obedience which at the same time is a form of individual differentiation.'[29] As such fashion is a role performance especially suited to those who are dependent upon the social acceptance of others yet who also seek personal pre-eminence.

The successful physician of 18th century England was a man of fashion in more ways than one. The leading Fellows of the Royal College adorned London society in the season, whilst more humble provincial physicians mirrored their activities at the county level. In addition practitioners extended the field of fashion into medical knowledge itself. The rivalries between the proponents of the various medical theories were part of the larger battle for power and prestige in the career system. Such contests were not intended merely for the delectation of other members of the profession, but were directed to an audience of fee-paying patients. Medical investigators were thus constrained to pay homage to the intellectual predilections of the upper class whilst simultaneously presenting their own individual interpretations of approved and traditional theories. As a result the 18th century systems of pathology were caught in a process of continual reformulation and revision, yet never succeeded in severing connection with a common set of assumptions about health and disease. Adherence to established theoretical premises assured social acceptability, whilst superficial novelty stimulated public interest and justified high fees. Thus the structure of the 18th century career system ensured that medical knowledge remained in a state of turmoil and controversy whilst at the same time prevented fundamental innovation in the underlying structure of medical thought.

5. *Science and Medicine in the 18th Century*

What opportunities existed in the medical world of the 18th century for the pursuit of scientific research into medical problems? In the period under

consideration there was little or no differentiation between the social roles of therapist and research worker.[30] Consequently medical investigators were unable to attain that degree of detachment from the opinions of patients which was necessary to foster a scientific approach to theory and practice. Both patients and practitioners regarded the activities of research scientists as irrelevant to the overwhelming problems of therapy which were their primary concern. An 18th century practitioner advanced his career by prescribing cures for symptoms rather than by discovering the causes of disease. There were few prospects in entering upon time consuming and laborious experiments which at best promised no more than limited and tentative conclusions. A physician's reputation was made by bold, decisive and immediate action to relieve his patient's suffering. As Sydenham remarked the obligation of the doctor was 'to cure disease, and do naught else'.[31] The sick and the dying could not wait whilst scientists discovered the causes of their agonies, and in any case they were more interested in remedies than in explanations. The speculative systems might have been unreliable and contradictory, but they did at least offer treatment and hope. In contrast scientific scepticism, and its attendant therapeutic nihilism, were cold comfort.

One of the most significant consequences of this situation was the neglect of the study of anatomy, and in particular of pathological anatomy which was to prove to be the cutting edge of scientific medicine in the Parisian clinical schools of the early 19th century. During the period under consideration the body and its ailments were widely regarded as the personal possession of each individual, a belief which the contemporary concept of disease did nothing to dispel. Access to the body was endowed with personal significance, and permitted only in the context of an intimate relationship. Public distrust of the medical profession severely restricted the opportunities available to practitioners and medical investigators to inspect the body, let alone conduct experiments upon it.[32] Physical examination was in the nature of a gift to be bestowed by one individual upon another. The occupational role of medical practitioner did not include a general mandate to undertake free and open clinical inspection of the bodies of patients. There was no institutionalized system of reciprocal exchange between doctor and patient in which personal information and confidences could be offered by the sick in certain expectation of guaranteed standards of ethical behaviour and medical care. Mutual trust within the consultative relationship was problematic, and had to be established in each case. Anatomical studies were restricted still further by popular revulsion at interference with the body even after death. Violent anti-dissection movements are a marked feature of western societies during this period. Dissection was widely regarded as an insult to the body and to the person. None but the corpses of the lowliest outcasts were permitted to be used for anatomical purposes, and then only in short supply. Such attitudes had a disastrous effect on the availability of cadavers for research, and severely depressed the social standing of those who engaged in pathological anatomy.

Social relationships among medical men themselves also seriously inhibited the development of scientific medicine. The social organization of medical personnel constrained practitioners to individually compete for clients by advertising their therapeutic skills. Consequently medical innovators sought occupational advancement by utilizing their discoveries in private practice, where they were often kept as trade secrets, rather than by sharing them with professional rivals. The free exchange of information among medical practitioners and investigators was impossible as long as clients, rather than professional colleagues, held control over the distribution of rewards in the career system. Thus it was not until the 1820s and 30s that medical journals devoted to the communication of empirical research findings were established on a firm footing, a century and a half after those of the physical sciences. Similarly medical societies were not formed in large numbers until the late 18th and early 19th centuries. Clearly a necessary, if not sufficient, condition for the growth of a scientific community is a network of relationships in which established wisdom can be freely deseminated to all acredited members. But, as Lefanu remarks, in the first half of the 18th century medical men found 'no professional sense of a united interest in the pooling of knowledge.'[33]

Among scientists the allocation of honours and rewards is based upon a relatively impartial process of validation and recognition of the published work of intellectual peers according to mutually agreed procedures. The accumulation of a body of scientific knowledge in this manner was not possible in the medical world of the 18th century.[34] Scientific medicine could not develop until the research workers themselves enjoyed the power to define legitimate standards of intellectual behaviour. Thus, for example, the pressure of competition for clients constrained practitioners to dismiss the discoveries of others out of hand whatever their objective merits might be. To have done other than this would have been to publicly acclaim the market value of a competitor's product.[35] Hence medical men played little part in the scientific movement of the late 17th century and early 18th centuries.[36] Indeed practitioners feared the criticism and rivalry of the scientific 'virtuosi', and the leading satirist of the Royal Society was sponsored by a fellow and benefactor of the Royal College.[37] The 18th century medical investigator who embraced experimental and scientific research could expect nothing, then, but hostility from the profession and suspicion from the public.

6. *Conclusion*

This paper has traced the consequences of social class patronage, the client/physician relationship, and the structure of the contemporary profession for the development of medical knowledge in 18th century England. A two-way network of dependencies existed between the sick and medical personnel. By virtue of their economic and political predominance the gentry and aristocracy held ultimate control over the consultative relationship and the course of medical

innovation. Physicians, on the other hand, enjoyed a measure of counter power over their patients, for the promise of physical and mental health held out by the profession was highly sought after by the sick. The systems of nosology and pathology were founded upon concepts of disease with which upper class patients could readily identify, whilst legitimizing the provision of therapy and the collection of fees by practitioners.

A more or less explicit theme of much work in the sociology of knowledge has been the contrast between substructure and superstructure, 'being' and 'conciousness'.[38] Conciousness has been regarded as an epiphenomena, to be explained by reducing its superstructural appearance to its substructural social basis. The objective of this paper, however, has been to examine a thought complex as an integral part of the structure of interaction in a configuration of relationships. It has been seen as a medium within which norms, roles, and expectations are expressed and institutionalized. Thus medical knowledge may be regarded as a form of social interaction which mediates between the disparate interests of the sick and medical personnel. In short medical theories may not only be statements about the world, they may also be ways of relating to others in the world.

Notes

1. A fuller version of the argument presented in this paper may be found in N. Jewson, 'Eighteenth Century Medical Theories: A Sociological Analysis', *Working Papers in Historical Sociology*, No. 1. (forthcoming), (Department of Sociology, University of Leicester).
2. The best general discussion of the social origins of medical theories remains R. H. Shryock, *The Development of Modern Medicine*, (New York, Knopf, 1947). Introductory descriptions of eighteenth century medical thought may be found in R. H. Major, *A History of Medicine*, Vol. 1 and Vol. 2 (Springfield, Thomas, 1954), pp. 479–639; F. H. Garrison, *An Introduction to the History of Medicine*, (Philadelphia and London, Saunders, 1929), pp. 310–406; D. Guthrie, *A History of Medicine*, (London, Nelson, 1945), pp. 215–265; S. L. King, *The Medical World of the Eighteenth Century*, (Chicago, Chicago University Press, 1958).
3. W. R. LeFanu, 'The Lost Half Century in English Medicine', *Bull. Hist. Med.*, Vol. XLVI, 1972, pp. 319–349.
4. The parallel with modern sociology is too good to be missed.
5. E. Fisher-Homberger, 'Eighteenth Century Nosology and its Survivors', p. 397, *Med. Hist.*, Vol. 14, 1970, pp. 397–403.
6. K. Faber, *Nosography in Modern Internal Medicine*, Chap. 1., (London, Milford, 1923); L. S. King, 'Boisser de Sauvages and Eighteenth Century Nosology', *Bull. Hist. Med.*, Vol. XL, 1966, pp. 43–51.
7. For detailed descriptions of classical medicine see E. D. Philips, *Greek Medicine*, (London, Thames and Hudson, 1973); R. E. Siegel, *Galen's System of Physiology and Medicine*, (Basel and New York, Karger, 1968).
8. See R. E. Schofield, *Mechanism and Materialism: British Natural Philosophy in an Age of Reason*, (Princeton, Princeton University Press, 1970). An alternative analysis critical of Schofield's approach is that of P. M. Heinman and J. E. McGuire, 'Newtonian Forces and

Lockean Powers: Concepts of Matter in Eighteenth Century Thought', *Historical Studies in the Physical Sciences*, Vol. 3, 1971, pp. 233–306.

9. E. G. Carlson and M. M. Simpson, 'Models of the Nervous System in Eighteenth Century Psychiatry', *Bull. Hist. Med.*, Vol. XLII, 1969, pp. 101–115; S. W. Jackson, 'Force and Kindred Notions in Eighteenth Century Neurophysiology and Medical Psychology', *Bull. Hist. Med.*, Vol. XLIV, 1970, pp. 397–410; L. J. Rather, *Mind and Body in Eighteenth Century Medicine*, (London, Wellcome Historical Medical Library, 1965).
10. E. Fisher-Homberger, 'Hypochondriasis of the Eighteenth Century—Neurosis of the Present Century', *Bull. Hist. Med.*, Vol. XLVI, 1972, pp. 349–359.
11. Discussions of social stratification in 18th century England may be found in: D. Marshall, *English People in the Eighteenth Century*, (London, Longmans, 1956); D. Marshall, *Eighteenth Century England*, (London, Longmans, 1963); G. E. Mingay, *English Landed Society in the Eighteenth Century*, (London, Routledge and Kegan Paul, 1963); H. J. Perkin, *The Origins of Modern English Society, 1780–1880*, (London and Toronto, Routledge and Kegan Paul, 1969), Part I; G. Rudé, *Hanoverian London, 1714–1808*, (London, Secker and Warburg, 1971); E. N. Williams, *Life in Georgian England*, (London, Batsford, 1962).
12. H. Perkin, *op. cit.*, p. 24.
13. On cultural differentiation in eighteenth century England, see A. Parreaux, *Daily Life in the Reign of George III*, (London, Allen and Unwin, 1969); A. S. Turberville, *English Men and Manners in the Eighteenth Century*, (Oxford, Oxford University Press, 1926); M. D. George, *England in Johnson's Day*, (2nd edition, London, Kegan Paul, 1930).
14. S. W. F. Holloway, 'Medical Education in England, 1830–1858: A Sociological Analysis', *History*, Vol. 49., 1964, pp. 299–324.
15. The comparative costs of medical education were calculated in 1697 to be £1,000 for the physician, £120 for the surgeon, and £50 for the apothecary. J. L. Axtell, 'Education and Status in Stuart England: The London Physician', *History of Education Quarterly*, Vol. X, 1970, p. 147.
16. For discussion of medical education at the English Universities during this period see: P. Allen, 'Medical Education in 17th century England' *J. Hist. of Med.*, Vol 1, 1946, pp. 115–143. A. M. T. Robb-Smith, 'Medicine at Oxford and Cambridge prior to 1850', in F. N. L. Poynter, *The Evolution of Medical Education in England*, (London, Pitman Medical, 1966), pp. 19–52; C. Newman, *The Evolution of Medical Education in the Nineteenth Century*, (London, Oxford University Press, 1957).
17. B. Hamilton, 'The Medical Professions in the Eighteenth Century', *Econ. Hist. Rev.*, Vol. IV, 1951, pp. 141–170.
18. See contemporary pamphlets, quoted by B. Hamilton, *op. cit.*, p. 164.
19. P. Laslett, *The World We Have Lost*, (London, Methuen, 1965), pp. 36–40.
20. See, for example, the influence of patronage upon styles of painting and print making, R. Wittokower, 'The Artist', in J. L. Clifford, (ed.), *Man Versus Society in Eighteenth Century Britain*, (Cambridge, Cambridge University Press, 1968).
21. R. D. Spector, *English Literary Periodicals and the Climate of Opinion During the Seven Years War*, (The Hague, Mouton, 1960), Chap. VI.
22. The best account of the advent of innoculation is that of G. Miller, *The Introduction of Innoculation for Smallpox in England and France*, (London, Oxford University Press, 1957).
23. J. H. Plumb, 'Reason and Unreason in the Eighteenth Century: The English Experience', in *Some Aspects of Eighteenth Century England*, by J. H. Plumb and V. A. Dearing, (Los Angeles, University of Los Angeles, 1971).
24. T. M. Brown, 'The College of Physicians and the Acceptance of Iatromechanism in England, 1665–1695', *Bull. Hist. Med.*, Vol. XLIV, 1970, pp. 12–30.
25. It is interesting to note that several valuable practical advances in medical care were made during the 18th century by a number of military surgeons such as Pringle and Lind.

This section of the profession was held in low esteem by the public and military alike, and in general the treatment it offered was probably very crude. However military surgeons differed from their civilian colleagues in two crucial respects (a) their patients were usually in no position to object to the therapy they received (b) they practised free from the constraints of the physicians. Consequently enlightened individuals were in a good position to implement new treatments and therapeutic regimens.

26. See, for example, Swift's description of Dr. Richard Helsham, quoted in T. G. Wilson, 'Swift and the Doctors', p. 212, *Med. Hist.*, Vol. 8, 1964, pp. 199–216. Claver Morris employed similar methods, E. Hobhouse, (ed), *The Diary of a West Country Physician, A.D. 1684–1726*, (2nd ed. London, Simkin and Marshall, 1935), p. 19.
27. See, for example, the apocryphal tale recounted by Mr. Urban, *Gentleman's Magazine*, Vol. 25, 1755, p. 74.
28. A similar state of affairs existed in other patient dominated medical systems. See, for example O. Temkin, 'Greek Medicine as Science and Craft', *Isis*, Vol. XLIV, 1953, pp. 213–225.
29. G. Simmel, *On Individuality and Social Forms: Selected Writings*, edited by D. N. Levine, (Chicago and London, Chicago University Press, 1971), p. 304.
30. Those who engaged in both activities sometimes had to endure role conflicts. William Harvey seems to have resolved his difficulties by maintaining a strict segregation between his therapeutic and scientific interests. Thus the discoverer of the circulation of the blood continued, in his professional capacity, to strongly recommend bloodletting which he justified by appeal to a Galenic rationale. K. D. Keele, *William Harvey: The Man, the Physician, and The Scientist*, (London, Nelson, 1965), p. 80–81.
31. D. E. Wolfe, 'Sydenham and Locke on the Limits of Anatomy', p. 202, *Bull. Hist. Med.*, Vol. XXXV, 1961, pp. 193–220. On these grounds Sydenham rejected pathological anatomy completely and only grudgingly endorsed gross anatomy. K. Dewhurst, 'Locke and Sydenham on the Teaching of Anatomy', *Med. Hist.*, Vol. 2. 1958, pp. 1–15.
32. Whilst patients might acquire confidence in their personal practitioners, the profession as a whole was subject to torrents of abuse and criticism in popular literature, journalism, drama, and illustration. See, for example, P. G. Brewster, 'Physician and Surgeon as Depicted in Sixteenth and Seventeenth Century Literature', *Osiris*, Vol. 14, 1962, pp. 13–26; M. Brightfield, 'The Medical Profession in Early Victorian England, As Depicted in the Novels of the Period (1840–1870)', *Bull. Hist. Med.*, Vol. XXXV, 1961, pp. 238–256; M. D. George, *Hogarth to Cruickshank: Social Change in Graphic Satire*, (London, Allen Lane, Penguin Press, 1967).
33. W. R. LeFanu, *op. cit.*, p. 347.
34. It is interesting to note that although the Royal Society made extensive statistical and other enquiries into the efficacy of innoculation against smallpox in the 1720's the Royal College made no such investigations, G. Millar, *op. cit.*, chap. 5.
35. See, for example, the reception of Jenner's discovery of cowpox vaccine, B. J. Stern, *Society and Medical Progress*, (Princeton, Princeton University Press, 1941), pp. 202–205.
36. Although quite a substantial proportion of the members of the Royal Society were medical men, they were largely reluctant or instrumental practitioners who earned their living from medicine, but whose primary interest lay in science.
37. D. Stimson, *Scientists and Amateurs: A History of the Royal Society*, (London, Sigma, 1949), p. 65.
38. For a critique of this tradition see N. Elias, 'The Sociology of Knowledge: New Perspectives' *Sociology* Vol. 5, 1971; Part I, pp. 149–168, Part II, pp. 355–370.

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