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Medical Professionalization: Pitfalls and Promise in the Historiography

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Aller au sommaire du numéro

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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.' 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,' a genre which Charles Rosenberg suggests is 'so thin and lacking in critical framework as to be of almost no use to succeeding scholars.' 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. Nor do definitions derived from present practice take into account vestigial criteria -- 'character,' for example -- once deemed essential to professional status. 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.' 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.' As Thomas Haskell has suggested, 'our inability to agree on an exact line of demarcation between amateur and professional, or profession

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and non-profession, does not make these categories them­

selves unintelligible. 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 dis­

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 un­
certainty, four general areas may be identified as particu­
larly germane to current historiography. First, is it pro­
ductive 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 profes­

A potentially serious pitfall in the use of the profession­
alization 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

10

in London, maintained close ties with the Royal Colleges, and usually held hospital and teaching appoint­
ments. 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 per­
sonal relationships among themselves and with the lay boards of governors who controlled the crucial hospital appointments. This divergence of interest between gen­
eral 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. 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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 facilitated.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.'\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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 hand, 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 dilettantes 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. 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, 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. 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. 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. Only the superstructure of medical education has been studied, leaving the most significant questions unanswered. 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. 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


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).


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