Introduction

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The social history of medicine has come of age. It is now possible to see in some detail the way in which medicine has developed within society. Whereas before the history of great doctors, great discoveries and great ideas was the staple diet of the history of medicine, now this new but flourishing branch of history gives us a sense of how medicine has affected society and how society has shaped medicine. In the process the definition of 'medicine' has been extended and deepened.

The contributors to this book show these changes, but they are only incidentally concerned with historiography, with how to write history. Their main aim has been with writing history itself, with giving to the reader some of the results of the new social history of medicine. Their chapters are synthetic and draw upon recent work in their fields, but they are also based on the primary research that each contributor has carried out.

Overall, this book shows that health care has been of perennial concern to Western society, but the forms it took have been different over time with modern State-influenced health-care systems, hospitals and professionalized practitioners contrasting strongly with the smaller, more open systems that existed before the nineteenth century. Running through the contributions are various themes. The balance of power in the patient–doctor interaction has changed over time. When medical practitioners depended on patients' fees and trade and the patient had a greater choice in practitioners, the patient tended to dominate: later, in the environment of the hospital and asylum, the doctor took charge and the patient increasingly lost control of events. The role of the state in medicine is another recurrent topic. This increased with time from its small beginnings in the Roman period, when civic doctors were given

tax immunities, and assumed large proportions in the nineteenth and twentieth centuries. Then the state came to legislate on the structure of the medical profession and to provide or oversee health-care schemes that delivered health care to all the population. Another thread that runs through the book is a concern with the demographic facts of life and death. In the pre-modern world the expectancy of life was low, infant and maternal mortality was high and for many it was in Katharine Park's phrase 'a universe of disease'. The ways in which this picture of mortality was improved is discussed in various of the contributions. Life and death are the ultimate concerns of medicine, and always have to be kept in mind in a social history of medicine.

In some ways the period from classical times up to and including the eighteenth century can be taken as a whole and seen as forming the first part of the book. In this period change was often slow and continuities abound. Highly original work has been done recently in this area. One of the innovations has been for historians to look at the multiplicity of medical providers that existed, without attaching to any one group a greater degree of significance than to any other. This mirrors the historical situation where an open, unregulated market place was the norm. In other words, the nineteenth- and twentieth-century values of the medical profession which in past history of medicine had been applied to earlier periods to condemn empirics, quacks, magical and religious practitioners have been discarded. In the process a much richer medical world has been uncovered.

Vivian Nutton in his chapter on the social history of Graeco-Roman medicine shows how at this time an open medical market place existed that was made up of a variety of religious, magical, empirical and medical practitioners. Anyone could be a healer, there was no licensing and patients drew on the services of what appear today to be practitioners holding radically different and contradictory belief. Self-help, especially in the countryside, was widespread. Illness was dealt with in the family: there were no hospitals in classical Greece. When in the Roman period hospitals were built they were designed to care only for two economically important groups, soldiers and slaves.

Katharine Park in her chapter on 'Medicine and society in medieval Europe, 500–1500' and Roy Porter on 'The patient in England: *c.* 1660–*c.* 1800' (the 'long' eighteenth century), indicate that very similar open medical market places existed in their periods. Before the industrialization of the nineteenth century change was often slow. However, there were some significant happenings.

The medicine of Hippocrates and Galen, the learned medicine taught by a lengthy process of education, tried to differentiate itself from other forms of healing during the classical period. It associated itself with philosophy which had high social status; it developed anatomical research, both as a spectacle and as a form of disinterested knowledge; and it gained patronage in royal courts such as Alexandria, and in fashionable Roman society. In the later medieval period the claims of learned medicine to form the elite part of the medical market place were strengthened by the rise of the universities with their medical faculties and set curricula, and by the establishment of city medical colleges or guilds which often claimed the right to control and license practitioners in their areas. Park points out that this marks the rudimentary beginning of 'professional medicine'; it did not have its nineteenth-century monopoly or power, and the rest of the medical market place remained largely unaffected. This situation continued to the eighteenth century.

Another event that influenced medicine was the arrival of Christianity. Charitable care of the sick was a peculiarly Christian idea and motivated the monastic care of the sick, and the building of hospices and hospitals. Moreover, as Christ had healed the sick so priests undertook the cure of the body as well as the soul.

The association of religion with medicine continued well into the eighteenth century if on a declining scale. The Catholic church had tried, from the time of the Middle Ages, to stop priests engaging in medicine for gain. The Reformation had stopped Protestants from healing by means of the sacraments which was regarded as Popish superstition (the age of miracles being thought to be long past). But until the processes of secularization in the eighteenth century began to reduce the significance of religion, Christianity remained a powerful force to be appealed to when ill, and rich and poor alike had recourse to religion even when they were using naturalistic medicine.

Porter's chapter describes the multiplicity of choice available in the medical market place in England during the 'long' eighteenth century, in which religion still played a role and when the vociferous claims of elite learned medicine to competence were met by the equally vociferous claims of the other members of the market place. Some changes in the continuity with the past did occur; the practitioners of regular, learned medicine increased from the end of the seventeenth century and made inroads into the numbers of certain types of lay healers such as wise women and cunning men (a process accelerated by the growing secularization of at least the middle and upper sections of society and the

decline of magic amongst them). The increasing commercialization of society also affected how people got their medicines, which were no longer collected from the fields but bought from shops. However, self-help and lay healing continued unabated. Roy and Dorothy Porter, have pioneered a new approach. They have written the history of medicine from the patient's point of view, which before was largely ignored.[1] In his chapter Porter, not only discusses the medical market place, but shows how patients had great control over their treatment: they frequently treated themselves, they exchanged information about cures and saw themselves as the equals of their doctors. Journals like the *Gentleman's Magazine* printed letters on medical topics from lay people and medical practitioners without distinction. The English medical culture of the eighteenth century gave patients near equality with their doctors. To end his contribution Porter looks at the voice of the mad, mad peoples' writings about themselves. Their numbers are very small, but the different ways in which the mad described their experiences shows us the diverse forces acting to give meaning to sufferers' lives. Madness as a psychomachy between the Devil and God, 'madness' as the unreal and unjust persecution by jailors or doctors, these are some of the meanings given to their condition by the mad. Meanings that refer less to medicine and more to society at large.

Andrew Wear's chapter also focuses on some of the meanings of health and illness. After briefly discussing how the meanings of medical theories of childbirth and of death changed from the sixteenth to the mid eighteenth century the contribution centres on perceptions of health and the environment in early modern England. That an unhealthy environment helped to create disease was well known in the sixteenth and seventeenth centuries. Little however was done about it. Food markets might be regulated, cesspits cleaned, the rubbish collected by parish scavengers, building restrictions imposed to reduce overcrowding, but the problem of the environment was thought to be getting worse, especially as the cities grew larger. Towns and cities, in particular London, were perceived as being less healthy than the countryside. This chapter explores how the environment and health were related by the use of the broad divisions of countryside and city. Transcending the

[1] Roy Porter and Dorothy Porter, *In Sickness and in Health The British Experience 1650–1850* (London, 1988); Dorothy Porter and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (London, 1989). What is new about their work is their emphasis on the voice of the individual patient; particular groups or populations in society such as mothers, infants, adults, minors, the old etc., are all as such 'patients' and have, as groups, long been the concern of the social history of medicine.

changes in medical theory that occur during the seventeenth century (from a humoral to a chemical and/or mechanical view of the body) ideas such as the need for an uncrowded, spacious, clean, light environment remained constant and were informed by references to the Garden of Eden, by folk knowledge, tradition, personal experience and by newly developing demographic research. The chapter again indicates how the social history of medicine, once it forgets the categories of professional medicine, can capture a wide range not only of experience but of meanings.

The eighteenth century, the age of the Enlightenment saw a period of change, not as rapid as the century that followed but a clear quickening of pace. The success of the 'new science' of the seventeenth century, the science of Newton, influenced many other disciplines. The theories of medicine changed in line with these new developments. Medical theories were no longer based on the four humours of the Greeks but on chemistry and mechanics. The human soul was abolished and the programme of reducing medicine to physics was underway; later, as the special nature of organic bodies was again brought to mind, the soul returned. Guenter Risse shows in his contribution, 'Medicine in the age of Enlightenment', that a sense of progress and of the perfectibility of society informed many Enlightenment developments in medicine. New medical theories and new systems of classifying disease replaced each other with startling rapidity, but despite the lack of effective cures the hope remained that progress in medical theory would have a practical pay off. Progress also took the form of an emphasis on a healthy life style and on personal hygiene based on the belief that illness was avoidable and that everyone could lead a healthy life, given a good enough education in medicine. The view that society could be medicalized was not new, there was a pervading interest in health from the Greeks onwards, but it was put on a more formal footing. In France, especially, the health of the poor became an object of scientific and medical interest and was researched by means of surveys. The medical regulation of life, by a system of 'medical police' was also mooted at this period.

Changes were afoot in the Enlightenment but the old structures of medicine only broke up in the nineteenth century. Many aspects of twentieth-century medicine had their origins in the nineteenth century. For instance, the rise of the hospital to a central position in medicine occurred after the French Revolution. Hospitals had existed since medieval times, founded for religious and charitable motives or by civic pride. In eighteenth-century Protestant England there were no longer

church-run hospitals, but civic philanthropy established instead the voluntary hospitals.

As Lindsay Granshaw indicates in her chapter on 'The rise of the modern hospital in Britain' the voluntary hospitals were charitable institutions catering for the moderately poor, and in the nineteenth century they were joined by the workhouse infirmaries that housed the destitute. The hospitals, therefore, carried with them the stigma of charity until the twentieth century. The family home remained the place for the well-to-do to be ill. As the nineteenth century progressed the voluntary hospitals were increasingly run by medical men, rather than by lay governors, who saw hospital posts as essential to their careers. The reforms in medical education in both France and England required practical on-the-ward experience and teaching and this meant that hospitals came to dominate the medical world. Medical research was also centred on the hospital. That patients came from among the poor did not detract from the status of hospitals, rather it gave a boost to hospital research and increased the power of doctors in the doctor–patient relationship. In hospitals physicians and surgeons did not have to depend on the fees or the trade of the patients housed in them; there was less need to listen to the patient and to tailor treatment to the individual patient's requirements. The patients were poor, less articulate, less troublesome, and it was much easier to carry out research on them (especially statistically based research which required large numbers in one place – the hospital). Moreover, the advantage of the poor was that the large numbers of post-mortems that were carried out would elicit no complaints from influential families.

As the hospital became more important, so medicine itself changed. In the eighteenth century disease was defined in terms of the subjective feelings experienced by the patient. In the new hospital medicine of the early nineteenth century the subjective feelings of the patient became less important (this was perhaps made easier as the hospital patient was no longer the paymaster). Instead, the doctor tried to find a specific locus of disease, often hidden from the patient. The patient was starting to be seen objectively, as an object, rather than being listened to as a subject.

A particular event, the French Revolution, shaped the new hospital medicine. Some of the medical reforms of the Revolution had been foreshadowed in earlier eighteenth-century France. Although there was a medical market place and the medley of practitioners was similar to that in England, elite learned medicine, especially surgery, was more tightly regulated by the Crown. The relatively high status of surgeons

presages their great influence in the new type of medicine, 'hospital medicine' as historians have called it, which was created by the medical reforms of the Revolution.[2] The Revolution gave central importance to hospital training; state regulations prescribed in detail how in the hospitals physicians and surgeons were to be trained. The reforms merged physicians and surgeons together and gave priority to the surgeon's approach: traditionally practical, hospital-based.

Another facet of modern medicine which had its origin in the nineteenth century was the professionalization of medicine. In France, the state prescribed how the new medical profession should be structured and in the process gave it a legal basis for its existence. In early nineteenth-century England medical reform was also in the air, but here it was more in the hands of medical men themselves. The Apothecaries Act of 1815 attempted to regulate the training of the 'regular' practitioners, but as Irvine Loudon points out it did not do away with the large numbers of medical corporations, nor did it provide 'one portal of entry' to the medical profession (something that the 1858 Medical Act also failed to accomplish). In his chapter on 'Medical practitioners 1750–1850 and the period of medical reform in Britain' Loudon argues that much of the medical reform was initiated by medical men rather than by the government.

His focus is on the general practitioner, one of the mainstays of modern medicine who perhaps had his origin around 1750. This was a time when incomes for medical practitioners were increasing. However, by the end of the century competition from the dispensing druggist, who began to sell medicine to the public rather than wholesale and to offer medical advice, impoverished many 'regulars' or general practitioners (often surgeon–apothecaries). The cry went up for a system of medical regulation that would exclude quacks (though the dispensing druggists were selling the same medicines as the regulars). As Loudon traces the medical politics of the time it is clear that cries for scientific medicine, for better medical education, more rigorous examinations, all had their altruistic side but were also mixed with financial and social considerations. The general practitioners failed to gain higher status and financial rewards, despite their attempts to reform medicine. Instead, hospitals and consultants dominated medicine as did the old corporations

[2] On this see Toby Gelfand, *Professionalising Modern Medicine. Paris Surgeons and Medical Science and Institutions in the 18th Century* (Westport, CT, 1980); Matthew Ramsey, *Professional and Popular Medicine in France, 1770–1830. The World of Medical Practice* (Cambridge, 1988); Erwin H. Ackerknecht, *Medicine at the Paris Hospital 1794–1848* (Baltimore, 1967); Michel Foucault, *The Birth of the Clinic* (London, 1973).

like the royal colleges, and the universities. In nineteenth-century novels the GP became a loveable character, but in the world of medicine he remained a lowly figure. This, despite the fact that the reforms had at first been initiated by GPs and had increased the general status of medicine. Indeed, medicine became fully professional. The Medical Act of 1858 gave a legal basis for the profession to control its own entry requirements, examinations and discipline, although unorthodox practice by practitioners not on the Medical Register was still allowed. The medical market place still continued, if on a diminished scale.

The state was also involved in the rise of public health medicine in the nineteenth century. As Katharine Park shows, in medieval and renaissance Europe, especially in Italy, states responded to repeated outbreaks of plague by instituting measures such as quarantine and by setting up magistracies, or health boards, with draconian powers over public health. The association of public health with government has been a long one. In the nineteenth century the health problems of large urbanized and industrialized populations, repeated outbreaks of cholera, and the developments of various social reform movements all directed attention to public health. Elizabeth Fee and Dorothy Porter in their chapter 'Public health, preventive medicine and professionalization: England and America in the nineteenth century' bring out the different meanings of public health in the first half of the century. For the French public health could ameliorate but not solve the problems of civilization. For Rudolf Virchow in Germany 'medicine was politics' and the right to health for the poor was part of political reform. In England, Edwin Chadwick thought that engineers held the key to public health for they could improve water supplies and sanitation. They, rather than medical men, were to be the agents of the public health reforms that the politicians were to direct. In England and on the continent public health was quickly dominated by medical men after the middle of the century. One of the great changes ushered in by public health was not only that the state controlled whole areas of life which before had been largely unregulated (conditions in the work place, hours of work, sanitary arrangements, water supplies, sale of food etc.), but also that the state came to know much more about the health of its inhabitants. Certain diseases became notifiable, surveys of health, illness and poverty were carried out, and industrial disease identified. This changed the way in which countries thought of themselves, and it also increased the 'medicalization' of society. One of the merits of Fee's and Porter's contribution is that it shows how, both in the United States and England,

the bacteriological revolution initiated by Pasteur and Koch in the later nineteenth century affected public health medicine. In the United States public health had taken off later than in Europe and had been a largely voluntary reform movement in which lay people dominated. With the advent of bacteriology in the United States a much more specific approach to public health was introduced. Medical experts replaced lay people, and rather than trying to improve the living conditions of whole, undifferentiated, populations they targeted people into specific 'at-risk populations' whose living conditions could be changed in appropriate ways. The political significance of public health medicine as an agent of reform therefore declined. The hidden hand of public health, however, still regulates many of our everyday activities, and the public health doctor is still much more concerned with the health of the whole community, with preventing disease rather than treating individual ill patients which has been the traditional concern of medicine.

Before discussing bacteriology and the creation of scientific medicine, one other early-nineteenth-century development which still influences medicine today has to be considered. The asylum rose in the nineteenth century and fell in the next. It was an institution that illustrates the forces of medical reform and state power, and is perhaps a further example of how the patient was becoming more of an object and less of a person.

The history of madness is one of the growth areas of recent historical research. The influence here of Michel Foucault has been immense.[3] He substituted a pessimistic account of the history of madness for the triumphalist description of medical progress that had been the norm. The work of Porter, Scull and others has modified Foucault's conclusions in the light of detailed empirical data.[4] For instance, Porter argues that Foucault's 'great confinement' did not occur in large parts of Europe when the mad, because of the new economic rationality of the later seventeenth century, were supposed to have been incarcerated along with the unemployed,the vagabond, the old and infirm and other work-shy groups. Instead, in England the 'great confinement' occurred in the nineteenth century.

Roy Porter's chapter on 'Madness and its institutions' shows how the incarceration of the mad increased dramatically from around 10,000 in 1800 to 100,000 by the end of the century. Up to 1800 the family and

[3] Especially Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (London, 1971).

[4] For instance, Andrew Scull, *Museums of Madness* (London, 1979); Roy Porter, *Mind-Forg'd Manacles. A History of Madness in England from the Restoration to the Regency* (London, 1978); Anne Digby, *Madness, Morality and Medicine. A Study of the York Retreat* (Cambridge, 1985).

the private lunatic asylums had looked after the insane. Although often treated brutally and considered to have the status of animals, the insane were not always seen as hopeless cases in the eighteenth century. Humane treatment and ideas on 'managing' the insane out of their condition (Francis Willis tried to master George III by his eye, the force of his personality) mixed with barbarous conditions and handling. However, a series of scandals at the turn of the century helped to bring reform to bear on the treatment of the insane. Throughout Europe an optimistic new viewpoint prevailed: the insane, it was held, should be freed from their restraints and chains and be re-educated back to sanity. The new institutions that were established, such as the York Retreat, put the new approaches into practice. They acted as the models for the state-run asylums which began to proliferate. However, as the asylums grew ever larger and silted up with long-stay incurable cases, optimism gave way to pessimism, drug treatment replaced personal contact, the asylum came to be a place of dread. In the history of the relationship between the patient, medicine and the state the asylum represents a particularly depressing example of the failure of early promise.

In the second half of the nineteenth century the most significant change was the emergence of scientific medicine. This helped to increase the status of medicine, but it decreased the power of the patient in the doctor–patient relationship which had already been significantly weakened by hospital medicine. The discovery of the cell and of bacteria, the development of antiseptic techniques, the integration of chemistry with physiology, pathology and therapeutics meant that medicine could finally share with science its status as the most sure form of knowledge. Moreover, as Granshaw points out, scientific medicine gave added weight to the status and role of hospitals. Laboratories and the equipment for new techniques such as x-rays were housed in hospitals. As the twentieth century began the middle class as well as the poor had to go to hospital if they wanted to take advantage of the new scientific medicine. The hospital was slowly losing its association with poverty and with charity. The patient, it can also be argued, became more of an object; the accounts of his or her illness became even less important. Now chemical tests would decide what was wrong.[5]

A great demographic change occurred at the beginning of the

[5] Two influential articles on patient–doctor relationships have been written by N. Jewson, 'Medical knowledge and the Patronage System in Eighteenth-Century England', *Sociology*, 8 (1974), 369–85 and 'The Disappearance of the Sick Man From Medical Cosmology, 1770–1870', *Sociology*, 10 (1976), 225–44.