Making a medical living

Doctors and patients in the English market for medicine, 1720–1911

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Introduction

The economic history of medicine is a strangely neglected field; relatively little is known as yet about the finances of institutions or the business side of medical practice. One reason for this may have been the emphasis given by an older tradition of medical historiography to the history of great men, clinical advances, and notable institutions. More recently, the expansion of the social history of medicine has directed attention to a much wider spectrum of concerns. Amongst these has been a desire to research more fully into the patient and the patient's experiences. Whether it is possible for the historian to gain direct knowledge of the patient independently of medicalisation is controversial.[1] One problem with this particular form of 'history from below', however, has been the difficulty of giving a coherent account that was more than a fascinating anthology of personal accounts of illness; a 'presentation and evaluation of ... attitudes and experiences.'[2] This volume is an attempt to advance the discussion by giving a more central place to the financial dimension of the patient's relationship with the practitioner, and thereby also to contribute to the economic history of medicine by looking at the doctor's income.

Doctors' incomes have a major influence on central issues in the social history of medicine. On the supply side, income affects the type of individual recruited to the medical profession; the status of the doctor in society; and the development of professional standards and professional attitudes. Remuneration has implications for the quality of medical care – most obviously in the time that the practitioner can afford to give to patients. On the demand side, the fees charged

[1] R. Porter, ed., *Patients and Practitioners. Lay Perceptions of Medicine in Pre-industrial Society* (Cambridge, 1985), p. 2.

[2] D. and R. Porter, *Patients Progress. Doctors and Doctoring in Eighteenth-Century England* (1989), prefatory explanation of rationale of volume.

clearly influence the numbers and types of patients who seek treatment. Ability to pay a qualified doctor affects the levels of health in society, and perceptions of what constitutes health. The fee levels also have an important bearing on the provision of related forms of medical care – as for example through private or public health insurance. Looking at the social history of medicine in the eighteenth and nineteenth centuries from a broad perspective, one of the major changes was the increasingly important role that professionals assumed in complementing lay care of the sick within the household. This change involved an extension of the market, so that ability to pay for the doctor became an important factor in standards of health care.[3] Patients' incomes were not the sole determinant of access to medical care, since normative considerations remained important, but capacity to meet the doctor's bill was a factor of growing significance. Ability to gauge the market in terms of demand for medical services at different fee levels was thus a crucial feature in successful medical practice. Whilst studies of professionalisation have drawn attention to ability to control the market,[4] there have been few studies of how this was attempted by members of the medical profession.[5] Two fine studies that give insight into this area from this point of view are those of Irvine Loudon and M. J. Peterson,[6] and this volume aims to complement them.

The concept of a market is sometimes used to refer to a particular institution (for example, Smithfield), or to a very specific exchange with a well-defined product and participant (for example, the housing market). It is used in this study in a less sharply defined sense to cover a looser relationship. On the one side are the suppliers of medical services – represented by a range of practitioners from the physician through the GP to the fringe practitioner. Their attempts to sell their own version of medical treatment, and thus to establish a practice by making a reputation which would attract and keep patients, are central to the analysis. The methods they used with different types of patients, and their concerns over fees and income from this medical custom are discussed. On the other side of the medical market were the patients, rich and poor, young and old, male and female; as

[3] P. Starr, 'Medicine, Economy and Society in Nineteenth Century America', *Journal of Social History*, 10 (1977).

[4] M. S. Larson, *The Rise of Professionalism. A Sociological Analysis* (Berkeley, 1977), p. xvi.

[5] For an interesting recent investigation see P. Weindling, 'Medical Practice in Imperial Berlin: the Casebook of Alfred Grotjahn', *BHM*, 61 (1987).

[6] I. S. L. Loudon, *Medical Care and the General Practitioner, 1750–1850* (1986); M. J. Peterson, *The Medical Profession in Mid-Victorian London* (1978).

consumers they had limited knowledge of what they were buying but needed to trust their practitioner. What they were purchasing, and what they thought they were buying, are also important in this investigation.

The time-span of *Making a Medical Living* is distinctive in looking at the longer-term dynamics of economic change for the practitioner and patient. This volume begins in the early eighteenth century, with the inception of the first voluntary hospital in 1720. The growth of these institutions gave social status to practitioners who held office in them, and an indirect means to expand private practice from the prominence that this élite position gave them. It also gave them direct access to clinical material. During the Georgian, Victorian and Edwardian eras discussed here, there was a significant increase in the number of offices – voluntary, charitable and public – and these, although frequently badly paid, formed an important element in attempts to construct medical practices that were financially viable. The end date of the volume is that of the National Insurance Act of 1911, which altered practice for many, by adding a large and publicly funded component to income from private practice. In looking at the financial relationships between practitioners and their patients, central attention is given to the GP (who treated most patients), but other types of doctor – notably the physician – are also discussed. In addition, an attempt has been made to direct attention much more onto the ordinary provincial practitioner rather than on the better-known London élite. In researching the book, much attention was given to archives in county record offices in order to try to recapture the realities of provincial practice, and thus to provide a more representative view.

The contemporary sources used in *Making a Medical Living* have been wide-ranging. The initial decision to attempt to provide greater insight into provincial practice resulted in many searches at county and borough record offices and local libraries, as well as at metropolitan libraries and archives. Whilst initial responses to enquiries indicated that relatively few repositories considered that they had much medical material, searches proved that the range and diversity of available material was very considerable. The time it has taken to research and write this book reflects their magnitude. Central to my understanding of medical relationships have been the diaries, letters, journals, autobiographical recollections, and accounts of patients, as well as those of practitioners. Institutional records in the form of hospital or dispensary casebooks, ledgers, reports, minutes, statutes and rule-books have been equally fundamental. To further illuminate practice with poor patients, poor-law overseers' accounts, contracts

and bills, together with later medical officers' registers, have been consulted. For private practice, ledgers, casebooks, and correspondence kept by the individual practitioner have been eagerly perused. Supplementing these have been editorials, reports, letters and advertisements in contemporary medical journals, notably the *British Medical Journal* (*BMJ*) and the *Lancet*, together with material (especially fee schedules) published by professional medical organisations. Data in medical directories and medical registers, together with the enumerations in the *Census*, have been serviceable, as have the reports of some parliamentary inquiries. Finally, prescriptive material has given some helpful insights; notably, the records of formal homilies and lectures addressed to medical students; professional manuals addressed to entrants to the profession; and health manuals directed to sufferers.

There have been methodological problems both in addressing and selecting from these sources. Only a small proportion of practitioner–patient encounters is likely to have been recorded and, of these, only an uncertain amount have survived. A substantial number of these records have been consulted, and an illustrative selection of the records themselves are discussed. But the extent to which these are representative of past relationships remains a very difficult issue. Interpreting these sources is thus problematical, since there is no single answer to the question of how much this past experience was homogeneous or heterogeneous. In some respects the historical practice is likely to have been reasonably uniform and even a small sample would provide a reliable indication, whereas for other topics there was probably considerable variety and it would be unwise to generalise on the basis of small, and possibly unrepresentative samples. Inferences as to what is typical or unusual are – at this stage of scholarship in the social history of medicine – a matter of judgement, informed by a partial insight which, as further detailed biographical or local studies are made, is likely to be modified. In part this is a familiar chicken and egg historiographical dilemma of whether it is best to direct research to general contextual studies or detailed individual subjects. Since each informs, and is mutually dependent on the other, there is no obvious intellectual priority to be given to one or the other approach.

The economic perspective of *Making a Medical Living* was an intrinsically interesting and significant one to investigate. However, a central focus on financial aspects of doctor–patient encounters – where objective quantitative material is plentiful – also facilitated generalisation. In discussing both quantitative and qualitative data a

range of confidence in its credibility is involved: at one extreme an upper limit involves hard information on incomes and fees which is unlikely to be disputed, whilst at the other end of the spectrum, a lower limit is concerned with subjects such as inferences on motivation, where subjective judgements may be more controversial. Predictably, there was no uniformity in the richness of sources of information; this has influenced the treatment of class, gender and age in Part III. It was found that the propertied groups were well-served by correspondence with physicians; the poor and children by institutional records, and women by abundant and varied sources. The chronological coverage is variable since sources for the later period are generally better; this is especially true for quantitative data. However for some subjects, notably the correspondence between affluent patients and physicians, this situation is reversed.

The two centuries that have been investigated have not only an economic, but also a therapeutic, coherence in that this was a period of what has been termed 'traditional medicine.'[7] Despite Foucauldian interpretation of this period as including the birth of modern medicine with the inception of the clinic, and the 'medical gaze' on 'what for centuries had remained below the threshold of the visible',[8] this volume emphasises that the forces for continuity in general (as distinct from surgical), practice were still resilient. So too was the continued importance of domiciliary as against institutional care of the sick. The overlap between older and newer practices and beliefs was thus considerable; the interplay between traditional and scientific, or between popular and élite conceptions of health and sickness was significant.[9] This suggests that Illich's allegations of the 'disabling impact of professional control over medicine',[10] need to be applied circumspectly, if at all, to the period in this book. Practitioners' potential influence was limited both by many sufferers' inability to pay for their services, even if they were desired, and by cultural assumptions which made other responses to illness more appropriate.[11]

[7] E. Shorter, *Bedside Medicine* (New York, 1985), p. 26. Shorter uses the term for the period up to 1850, but for reasons advanced in Chapter 3 I have extended this to 1911.

[8] M. Foucault, *The Birth of the Clinic. An Archaeology of Medical Perception* (New York, 1973), pp. ix–xii.

[9] M. Macdonald, 'Anthropological Perspectives in the History of Science and Medicine', in P. Corsi and P. Weindling, eds., *Information Sources in the History of Science and Medicine* (1983).

[10] I. Illich, *Limits to Medicine* (1977), p. 11.

[11] See, for example, M. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol* (Cambridge, 1991), Chapter 2.

In this volume, the longer-term perspective adopted makes it possible to suggest some of the shortcomings of the conventional, and somewhat simplistic, view of the changes to the modern from the traditional,[12] not just in clinical practice but in professionalisation as well.[13] A closer look at the importance of the financial relationship between practitioner and patient soon suggests some of the deficiencies of seeing the process of medical professionalisation as a simple power relationship in which doctors increasingly dominated their clients. Instead, a complicated picture emerges in which there is a more even balance between the financial standing of the patient and the clinical expertise of the doctor. To see this as an uncomplicated act of patronage would be misleading, however, since an economic transaction between doctor and patient was infused with cultural assumptions and expectations. These attitudes were themselves highly differentiated, as chapters on selected groups of patients indicate. Medicine, even for the regular members of the medical profession or Faculty, was an occupation which still retained strong elements of trade. To counteract this, both medical education and medical etiquette emphasised the importance of social aspects of practice, with appropriate demeanour, appearance and behaviour befitting not just professional but, crucially, genteel status.

In his famous preface to *The Doctor's Dilemma*, George Bernard Shaw wrote a savage indictment of the predominantly private medicine that is the subject of *Making A Medical Living*. 'Nothing is more dangerous than a poor doctor ... Of all the anti-social vested interests the worst is the vested interest in ill-health.'[14] Does the historical record indicate that doctors were in reality poor and their conduct anti-social? Part II of this volume (Chapters 4–6), on the finances of medical practice, indicate that there was very considerable variation in medical income. When Shaw was writing, in the early twentieth century, the struggle to make a living from medicine was certainly becoming much more difficult. The financial imperative was therefore even stronger than had usually been the case earlier. During the two centuries discussed in this volume, doctors' struggles to first create and then maintain an economically viable practice – either through fees from private practice or through remuneration from public or charitable appointments

[12] For example, 'the professions as we know them are very much a Victorian creation' in W. J. Reader, *Professional Men. The Rise of the Professional Classes in Nineteenth Century England* (1966), p. 2.

[13] L. J. Jordanova, 'The Social Sciences and the History of Science and Medicine', in Corsi and Weindling, eds., *Information Sources*, pp. 90–2.

[14] G. B. Shaw, *Prefaces*, (1934), p. 280.

– were unremitting. Success in the form of wealth went to a very small minority of doctors. Rather more made a comfortable income, many scraped by on an income that scarcely bought gentility, and a surprising number failed to make a living at all. That there were so many less-than-affluent doctors exposes the hidden contradiction in the quotation from Shaw, since if they had been sufficiently mercenary, more should have been able to make a decent living. However, this also assumes that there were sufficient affluent patients for the number of practitioners, and that these were distributed equitably between them – assumptions that were belied by historical reality.

Part I of the book (Chapters 1–3) provides the context for understanding the practitioners' predicaments. These chapters attempt to synthesise a large amount of primary and secondary sources in order to provide the essential historical building blocks on which the more original interpretation can be erected elsewhere in the book. It is suggested that the presence of fringe practitioners (variously termed irregulars, empirics or quacks), continued to give strong competition to the regular practitioner, not least because of the considerable overlap in the kind of therapeutic help they offered to sufferers. However, the availability of regular practitioners varied, as did that of unorthodox practitioners, so that sufferers' choice of the kind of practitioner they consulted showed marked regional variation. Nineteenth-century legislation failed to give a medical monopoly to regular practitioners despite their attempts at professionalisation which were driven by a desire to restrict competition. Competition for patients thus remained severe, and from the mid-eighteenth century doctors showed marked commercial flair and versatility in their attempts to expand the medical market by keeping business records, by actively pursuing patients through increased travel, and by flexibility in the exploitation of changing market opportunities.

The incidence of morbidity (sickness) was only slowly reduced by preventive measures in public health, by improvements in living standards, and by the relatively few scientific advances in the prevention and cure of diseases. In winning the patient's confidence the social attributes and personal manners of the doctor were thus imbued with considerable importance. Increasingly this was reinforced by some enhancement in medical authority which derived substantially from the considerable achievements of surgeons, yet in popular perception was also attributed to the physician and GP. Routes to the achievement of a viable medical practice in a rapidly increasing Victorian population were differentiated into a three-tier medical market. Part III (Chapters 7–9) of *Making a Medical Living* looks at selected groups of

patients within this market in analysing the extent to which relationships between practitioner and client were shaped by economic rather than other factors. Chapter 7 discusses the interaction between physicians and affluent Georgian and Victorian patients which, on *a priori* grounds, might be thought to exemplify most clearly a patient-dominated patronage relationship.[15] Instead, it suggests that the physician offset patient power by claims to medical expertise in health as well as sickness. Similarly, Chapter 8 examines a marked growth of remunerated medical practice amongst the poor from the mid-eighteenth century, through voluntary, charitable and publicly-funded initiatives which benefited the surgeon, surgeon-apothecary and the GP. Whilst these offered a variety of financial rewards it is also suggested that there was a substantial amount of professional altruism provided by practitioners to poor patients in the form of free treatment. Chapter 9 analyses practice in two linked areas in which expansion in medical practice was also found during the late eighteenth and nineteenth centurries – that of women and children, and suggests that remunerative practice resulted. This is linked to inter-professional rivalry with midwives, and with hostility to women entering the medical profession, since each would offer strong competition.

In Part IV, a final chapter, 'Reflections', attempts to draw out some more general implications of the nature of the relationship between practitioners and patients within the medical market. It examines the extent to which the patient prospered, in the sense of achieving well-being, and thus an absence of dis-ease. And it underlines the point that it is not just the financial prosperity of doctors that is the focus of attention in this volume, but the extent to which they were respected, and their views accorded authority. In doing so it returns to what was the underlying issue in the best-known discussion of this issue – Shaw's *The Doctor's Dilemma* – in which there is an idealisation of motives and self-justificatory processes by the practitioner.[16] The volume ends by asking whether doctors prospered in this wider meaning of self-worth, of making sense of what s/he did, rather than in the narrower sense of wealth.

[15] N. D. Jewson, 'Medical Knowledge and the Patronage System in 18th Century England', *Sociology*, 8 (1974), pp. 369–85.

[16] M. Holroyd, *Bernard Shaw. Vol. II, 1898–1918. The Pursuit of Power* (1989), p. 159.