ROY JAMES SQUIRES

Marginality, Stigma and Conversion in the Context of Medical Knowledge, Professional Practices and Occupational Interests

A Case Study of Professional Homeopathy in Nineteenth Century Britain and the United States

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Department of Philosophy
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ABSTRACT

During the development of medicine in nineteenth century Britain and the United States, the 'regular' profession was faced with severe competition from 'unorthodox' practitioners. Most significant amongst these were the professional homeopaths. They were just as well educated and qualified as the regulars, and so they posed the deepest threat to their continued plausibility as the source of all that was 'Good', 'True' and 'Scientific' in professional medicine. The cognitive anxiety which professional homeopathy raised was further intensified by the fact that recruitment to the ranks of homeopathy was made from the regular profession itself. Many converts to homeopathy were prepared to pay the professional and personal costs of being labelled a 'quack' for the sake of their own integrity and the apparently more effective therapeutic certainties of homeopathy. They were prepared to abandon the systems of regular medicine, be they heroic, sceptical, neo-vigorous or eclectic, in order to be at peace with their own conscience, and to practice a system of medicine they were now convinced was far more effective than any form of regular therapy.

During this period, regular medicine passed through three basic styles of theory and practice. These were the Heroic-Bedside, Clinical-Hospital and Bacteriological-Laboratory Medical Cosmologies. Particularly during the Heroic and Clinical phases, the regulars developed an anti-homeopathic ideology which they

deployed in the various conflicts which ensued. Its purpose was to define the homeopaths as 'deviants' and medical 'heretics'. The regulars did this by the use of a 'vocabulary of insult' which stigmatized their opponents. By further employing the tactics of intolerance and social control they were able to secure their own claims to political and 'scientific' legitimacy. However, the supposedly 'rational' and 'scientific' refutations of homeopathy by many eminent regular practitioners (such as Oliver Wendell Holmes and James Young Simpson) were actually constructed at a time when the therapeutic, pharmacodynamic and aetiological knowledge of regular medicine was immature and highly uncertain.

I shall argue that the claimed refutation of homeopathy during the 1830's to 1860's was not, indeed could not be, accomplished on scientifically 'objective' grounds (i.e. on the grounds of intersubjectively testable, empirical and experimentally reproduceable knowledge). Therefore, its actual grounds were those of conventional professional social norms, practices and traditions. The defence of regular medicine by means of an anti-homeopathic, anti-quack ideology and the rhetorical claim to 'scientificity' was a sign of an insecure and crisis-ridden profession. It was dangerous for regulars to admit, both professionally and personally, the therapeutic efficacy of homeopathy claimed by its adherents. For the majority of the regulars, the cost - emotional, cognitive and social - would

be too high. In these terms (rather than mere professional duplicity) we can explain the attempted suppression of the statistical returns of the London Homoeopathic Hospital, which showed the success of their treatments, from the official report on the 1853/54 cholera epidemic.

A mature scientific therapeutics began to develop with the emergence of the bacteriological research programme, based upon the work of Robert Koch. He was able to provide a secure experimental, methodological and ontological basis for the germ theory of disease causation. However, its therapeutic fruitfulness was not realised in practice (for people that is) until the 1890's, with the mass manufacture of diphtheria anti-toxin based upon the research of Emil von Behring. Therefore, the known development of medicine, and especially of therapeutics, does not support the claim by the regulars during the nineteenth century (and after) that homeopathy was refuted by unambiguous experimental, clinical and 'scientific' means. The actual means to do that did not emerge upon the historical scene until 1876 at the earliest (with Koch's bacteriological work) and with fuller effect not until the 1890's. However, by that time the conflict between regular and homeopathic practitioners was no longer of any interest to the centres producing standardized scientific knowledge; the bacteriological laboratories of university-hospitals, the proprietary drug industry, and various government and private research institutes. The 'refutations' of homeopathy developed a half-century earlier,

were taken to be sufficient warrant to continue to (a) reject homeopathy cognitively, if not legislatively, and (b) refuse it the courtesy of agreed experimental test when the actual means to do so were then available.

Therefore, within the asymmetries of power, structures of domination and mechanisms of social control developed by the regulars in their pursuit of 'scientific' legitimacy, occupational closure and market monopolisation, the homeopaths were marginalized. However, they were not completely powerless against the regulars. They were able to obtain some important compromises and concessions from them, even if what was gained in America turned out to be far more temporary compared to the moral and legislative achievements of their less numerous British counterparts.

The medical historians standard model to explain the '<u>success</u>' of 'scientific' regular medicine and the '<u>failure</u>' of 'unscientific' homeopathic medicine, as the result of the progressive, linear, accumulation of 'facts' is no longer adequate to the task. This is because of the model's/historian's assumptions that the ideological evaluations already performed in relation to those it has stigmatized as 'unscientific' and (or because) 'unorthodox', during the nineteenth century, were (and are) epistemologically 'True' and unpolluted by political/ideological interest. It is the purpose of this work to demonstrate that such a science/ideology polarity is unable

to adequately explain the historical rejection of homeopathy throughout the century and to propose a conception of monopoly, marginality, power and ideology which is adequate to that task.

ACKNOWLEDGEMENTS

This work originally began as an investigation into the medical systems of homeopathy, acupuncture, osteopathy and chiropractic. However, the bibliography began to grow so fast that I chose to concentrate upon homeopathy due to the high quality of work done on it in the U.S.A. and the interesting incidents I was uncovering about it in Britain.

Throughout it all Dr. Jerry Ravetz has been a constant source of intellectual encouragement, and our discussions have provided many fruitful ideas and questions to pursue. My wife, Kathy, provided the creature comforts of peace and quiet as well as regular cups of coffee and tea whilst I 'hibernated' in my study. I would like to say how grateful I am to her for reading my work and providing some helpful criticisms of style and structure. She, the children, and our friend Lynn all helped to keep me 'sane' and down to earth as much as they could. Even so I would still get caught up in either some historical minutiae, or theoretical speculation at times. In the latter case I would discuss them with Dr. Richard Kilminster from time to time who provided a patient and enthusiastic socio-logical ear for them.

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DEDICATION

To Jerry and my wife Kathy who between them never lost sight of the meaning of the margins for all those who are forced to live there.

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INTRODUCTION

1. MOTIVATION

As I was working on source materials in several potential research projects, my interest increased in the historical and sociological study of the relationship between 'regular' and 'deviant' medicine. The academic, historical and sociological work of the twentieth-century revealed a more or less systematic omission of the history of homeopathy, except to stigmatise it as 'pseudo-scientific medical quackery'. The omission was more extensive within the British literature, compared to the American literature covering the same period. I thought the difference was probably due to different policies of the homeopathic practitioners, styles of local and national government and traditions of thought and policy regarding perception of the threat from irregular practitioners.

Other anomalies related to the present-day status and legitimacy of professional, i.e. licensed and registered, homeopaths. These had their origins in the nineteenth-century relationship of regular practitioners to homeopaths. Homeopaths have legal status by means of the Medical Act, 1858 and the Faculty of Homeopathy Act, 1950. They also work within the National Health Service and provide homeopathic therapeutics as part of their private practice. They are trained, licensed and registered as regular practitioners

but have the additional post-graduate qualification of 'Member of the Faculty of Homeopathy'. They continue to be denied any state finances for scientific research. These funds are allocated by a state board basically controlled by the representatives of the regular medical institutions, who accept the standard anti-quack ideology regarding irregular practitioners, no matter how well qualified they initially are in establishment qualifications. Due to this state of affairs professional homeopathy is available only as a two-year post-graduate qualification. The finances for this are made available by a registered charity, 'The Homeopathic Trust'. This trust was established in 1948 to raise and administer funds for the educational and research work of the Faculty of Homeopathy which is based at the Royal London Homeopathic Hospital, Great Ormond Street.

Other anomalies became apparent when I compared homeopathy with other deviant/irregular medical specialities such as acupuncture. This can be found being scientifically and clinically investigated by regular medical practitioners at teaching and research institutes, in marked contrast to homeopathy.

The questions that arose in my mind were of a sociological and historiographical nature, viz. 'How did such a relationship between licensed regular and homeopathic practitioners, their medical knowledge and practices, come about?' Such a question would mean investigating issues relating to specific events,

processes and long term developments. These are issues to which we can turn our attention once the thesis, problematics, theoretical and methodological orientation have been clarified.

2. THESIS

My thesis derives from deep historical and sociological problems arising directly from an analysis of the ideology and development of 'scientific' medicine in relation to that of homeopathy. It has two aspects to it.

2.1. When Did Medicine Become 'Scientific'?

My first claim is that, historically, regular medicine did not begin to become at all 'scientific' until quite late in the nineteenth-century; nor could it until certain technical, methodological and substantive advances had been made in medical theory and practice. This claim holds especially true in the field of therapeutics in Great Britain and the United States.

By the term 'scientific' I refer to that body of historically reviseable and experimentally produced knowledge which is theoretically specialised and empirically certain. The obscurity at its foundations (i.e. fundamental categories of experience) provides an endless source of creativity at the frontiers of research. However, for practical purposes this obscurity and

ambiguity is ignored. In fact the ignoring of such obscurity is a mark of a mature scientific discipline.

In terms of the above characteristics nineteenth-century medicine generally, and therapeutics in particular, could hardly be regarded as 'scientific' throughout the nineteenth century. It may have used some of the tools and rhetoric of science but that does not and did not make it theoretically and empirically powerful, comprehensive, systematic, experimentally testable and predictive knowledge. Philosophical conflict between rationalists and empiricists, vitalists, materialists and mechanists continued throughout the century. Some programmatic statements of what 'scientific medicine' should look like were made by practitioners like Francocis Broussais, John Brown, Elisha Bartlett, John Forbes and others. Except for a few therapies like vaccination, quinine and diet; some surgical advances such as anaesthesia and aseptics; and improvements in public sanitation and quarantine, little in regular therapeutics could be considered really effective and minimally iatrogenic. Whether homeopathic therapy was (or is) more effective has never really been put to rigorous, experimental, clinical test.

'Scientific' or 'regular' medicine began to resolve some of its basic therapeutic problems with the demise of heroic medicine as a system and the emergence of clinical-hospital medicine. However, clinical medicine oscillated between sceptical,

neo-vigorous, and eclectic therapeutics. Each was at a point on a spectrum ranging from heroicism to nihilism, all of which were practised by regulars during the second half of the century. However, the quality of aetiological knowledge really began to change with the emergence of the bacteriological-laboratory research programme from the mid-1870s onwards. It will be argued here that Koch's exemplary research, of 1875/76, with the anthrax bacillus was the work which enabled the bacteriological research programme to 'take-off'. Its 'scientific' foundation was the germ theory of disease which he placed upon a demonstrably experimental footing and provided it with ontological status. However, he could not have achieved his success without the preconditions of quite specific innovations in microscopy, culture medium, and staining techniques which were all available by 1875 and only by 1875.

Even though this revolution in theory and practice was occurring, as late as the 1890s many medical teachers and practitioners, some as eminent as William Osler (1849-1919), were still therapeutic sceptics, even nihilists. Yet under conditions of such therapeutic doubt the mid-nineteenth century arguments of regular practitioners like Oliver Wendell Holmes (1809-1891) and James Young Simpson (1811-1870), against homeopathy, were still being employed and still being claimed to be 'scientific' and/or rational refutations of homeopathic therapeutic claims. This was at a time when the criteria used to evaluate therapeutic efficacy were not mature enough to

provide an experimentally reliable evaluation of the efficacy, or otherwise, of homeopathy or indeed of any variety of 'regular' medicine.

2.2. A Crisis of Legitimacy

Secondly, the regular practitioners, although under internal threat and tension from changes in medical cosmology, were able to retain commitment to occupational traditions and practices whose substantive contents seemed to exhibit little therapeutic certainty. At the same time they were able to mount an ideological offensive upon various 'alternative' medical practitioners, some of whom claimed 'professional' status and 'scientific' legitimacy - such as the qualified homeopaths. The contradiction of this situation lay in the fact that such an offensive against the homeopaths was carried out on the assumption (some would claim pretence), that regular medical theory and practice was founded upon the solid ground of scientific certainty and legitimacy.

In some cases (notably Oliver Wendell Holmes) a single person would exhibit the tensions and contradictions of current regular medical practice, and simultaneously denounce homeopathy for its lack of 'scientific' foundations.

This poses the question of how regular medicine was able to sustain its own occupational and epistemic continuity in the

face of increasing uncertainty as to its traditional theories and practices, resulting in criticism from within and without and significant defection from its own ranks into various alternative medical cosmologies, notably the homeopaths. The solution lies in the structures and asymmetries of power and how the regulars were able to mobilize them in a campaign against the homeopaths. This involved campaigns to delegitimate and marginalize them; to deny them access to the social, political and occupational privileges of social honour, status and recognition which were ideologically monopolised by the regulars, particularly the physicians. This especially political activity 'held the line' for regular medicine until late in the century when the 'bacteriological revolution' held out the hope of genuinely 'scientific' therapeutics.

3. THE MAIN PROBLEMS FOR STUDY

3.1. Why was professional homeopathy, in nineteenth century Britain and the United States, labelled as a 'medical heresy' by the organized regular profession?

3.2. How was this labelling accomplished by the regulars and resisted by the homeopaths? Specifically:

(a) What strategies were used by the regulars to render the homeopaths marginal to themselves and to their claims to legitimacy, status, social honour and political advantage.

(b) What strategies were used by the homeopaths to resist the measures employed by the regulars?

3.3. What were the significant features of the conversion experience of some regulars who came to believe in and practice professional homeopathy?

3.4. What were the main outlines of medical knowledge and practice in the regular and homeopathic professions?

3.5. What is the most adequate way to theorise about the above issues?

3.6. What are the implications of the proposed solutions to the above problems for the received history of medicine and its evaluation of Hahnemann and Homeopathy?

4. PROBLEM SOLUTIONS

Here I indicate my solutions to the problems proposed in the previous section.

4.1. Homeopathy was a deep threat to the continued cognitive, social, political and occupational plausibility of the regular profession during its heroic, neo-vigorous and sceptical phases of practice. Consequently, during a time of internal crisis, and lack of public confidence homeopathy seemed to provide certainties which many sought in therapeutics as well as a 'professionalism', patronage, public appeal and livelihood at least equal to, often better than the regulars.

Due to this intensive threat to the plausibility of 'orthodox' medicine, many fears and anxiety were evoked which led to the campaign to deviantize and variously deny its legitimacy, especially legislative and 'scientific' legitimacy.

Eventually, the homeopaths were outnumbered and outmanoeuvred by the regular practitioners who were able to gain and maintain more politically advantageous legislation. They were also beginning to be more therapeutically fruitful and innovative by the 1890s onwards.

4.2. The regular practitioners, even under conditions of changing medical knowledge and practice and political fortunes, were able to deploy and draw upon an established anti-quack ideology and construct a new 'demonology' to include the homeopaths and others, i.e. Thomsonians and Eclectics in the United States during the first half of the nineteenth century; Mesmerists and Hydropothists in Great Britain during the similar period. Thus, the homeopaths were successfully labelled as 'quacks', 'heretics', 'charlatans', 'knaves', 'fools' and 'evil men'. Their beliefs were labelled as 'quackery', 'heresy', 'irrational', 'mad', 'vain imaginings' and 'illusions'. Their supporters and clientele were regarded as 'idiots', 'knaves' and 'fools'.

The specific strategies and tactics involved in deviantizing the homeopaths are empirically described in the historical

sections (chapters 4 and 5) and a descriptive theory of marginalization elaborated (in chapter 6) which dovetails into the Weber-Berlant monopolization thesis. These processes are set within wider considerations of a theory of power, domination and control.

During the above descriptions and discussions the strategies of marginalization and its resistance are elaborated in terms of deviantization, stigmatization and purification. The strategies of resistance are not theoretically separated from the marginalizing activity of the regulars so that we can understand them as being in a close reciprocal relationship when such processes do occur.

4.3. Some regular medical practitioners were converted to homeopathy for many individual reasons, but in general they were regular practitioners dissatisfied with regular practices and for the sake of conscience and personal integrity could not continue as regular practitioners. They were often searching for certainty, in therapeutics in particular and medical knowledge in general. Encountering practitioners whom they respected and who were also homeopaths, they were both sceptical and yet curious about the claims made for this therapeutic practice. Experimenting with some of the homeopathic medications they were surprised to see that it 'worked'. Eventually, some were won over to the new 'medical gospel' and evangelized others in various ways.

However, the costs of conversion were considerable and the various strategies used to monopolize the medical market place and marginalize the homeopaths as immoral, insane, unprofessional and unscientific, made conversion socially, cognitively and emotionally costly for converts. Neither was conversion necessarily instantaneous since many took a year, or even several years, to reach the decision to become a professional homeopath.

Once conversion had occurred the social psychological and organization problem then became one of sustaining the plausibility of the new beliefs and turning the converts into committed members. These social involvements together with the practice, defence and extension of homeopathy all contributed to the constitution and consolidation of the convert's new identity as a professional homeopath.

4.4. Some of the worst features of heroic regular medicine were being remedied by mid-century through recourse to <u>expectant</u> therapies, i.e. a sceptical or nihilistic approach. This was soon followed by <u>neo-vigorous</u> therapeutics, in the 1860s and 1870s onwards. It seemed that the raison d'etre of the differences between homeopaths and regulars was disappearing as regular medicine developed therapeutic specifics of high quality by the 1890s onwards. However, I must say that I feel justified, with hindsight, in saying that the full integration of homeopathy never took place because of the pre-formed, standard, anti-

quack ideology of the regulars, in which the homeopaths were still a part of the coven of 'medical demonologies' constructed in the 1830s to 1850s. During this time, systematic and 'objective' clinical tests of therapies in the materia medica were either not available or very immature as regards their evaluative criteria.

From the 1870s, especially with the emergence of the germ theory of disease causation and the implications this had for the rise of 'scientific' therapeutics, the popularity of homeopathy began to wane. The regular profession seemed to be going in a definite direction, theoretically, clinically and therapeutically, whilst the homeopaths seemed to come up with nothing that was theoretically or empirically novel. The excitement and novelty of the germ theory of disease and the research programme articulated on the basis of it, revitalized and refashioned images of an imminent medical millenium and tied this closely to the whole image of 'progress' which dominated political, social and scientific thought in the second half of the nineteenth century in the United States and Great Britain.

In order to see these developments in context an outline of homeopathic knowledge will be provided, as well as details of the Heroic, Clinical and Bacteriological cosmologies of the regulars. This will provide the epistemic context for the ideological conflict between them.

4.5. Crucial to an explanation of these questions is the Weber-Berlant thesis of Monopolization and Occupational Closure. This proposes the historical and social construction of a professional project of increasing dominance of the medical market to remove uncertainties regarding career, status and income. Control is thereby extended over those areas to increasing numbers of socially and politically recognized regular medical practitioners. However, I have widened the systematic consequences and implications of this to the empirically available processes of marginalization and stigmatization in order to formulate an informal descriptive theory of marginality applicable to the development of regular medicine in relation to the professional homeopaths.

Examination of these processes highlights those aspects and consequences of the increasing monopolization of the medical market place, from the point of view of those who are deviantized, stigmatized or eliminated from the competition. This also highlights the characteristic dilemma facing any marginalized and stigmatized group which requires 'legitimacy' for itself on the basis of criteria established and maintained by the dominant group. The dilemma is that the criteria of legitimacy entails their own deviance if they continue not to approximate to those criteria in their knowledge and practices. Hence any degree of conformity to such criteria entails a corresponding reduction in the distinctiveness of their beliefs and practices, and a consequent threat to their identity.

The asymmetries of power successfully gained, maintained and gradually extended by the regular practitioners over the century eventually marginalized the professional homeopaths in various ways. This task was not easy at all. In fact the reciprocal nature of relations of autonomy and dependence meant that the homeopaths were able, in some instances, to strategically alter the institutional, political and cognitive attempts to eliminate or contain them, by mobilizing their own resources of power. For example, in Britain, a clique of regulars, making up an official government medical committee, failed in their efforts to suppress the therapeutic and clinical data supplied by the homeopaths, on cholera treatment, from the official government report (1855) on the 1853-54 cholera epidemic.

However, with the apparently increasing effectiveness of regular modes of treatment and legislative advantages gained from the polity the regulars acquired that which they had constantly courted during the century: the legitimations of science and government for their particular cosmology and its practitioners.

4.6. The standard history of medicine has assumed a model of the development of 'scientific medicine' which is cumulative, linear and progressive in order to explain the rise of modern medicine and the success of its practitioners. Built into this are the further assumptions that 'scientific' medicine could be easily identified in an unproblematic way: it was what educated,

licensed, or registered doctors did and was to be found in the journals and text books of medical 'orthodoxy'. Anything outside this boundary was labelled as 'unscientific', even if, like the professional homeopaths in Britain, you happened to have negotiated your way into the legal definition of a 'registered practitioner'. This model ignores the sociologically obvious fact that such boundaries are the result of 'negotiation' in the context of conflicts of interest, ideology and power.

The model also assumes that 'scientific medicine' has a privileged epistemological status and is free from the 'polluting' effects of ideology and occupational interests. This dichotomy between science and ideology is challenged here, as is the assumption that ideological and other interests are somehow alien or foreign to the production of 'scientific' medical knowledge.

This standard view of the development of 'scientific' medicine is not adequate to the task of explaining how and why homeopathy, as a serious challenger to the prevailing medical orthodoxy for much of the century, eventually failed in its challenge.

5. CONCEPTS AND METHODOLOGICAL STRATEGY

5.1. General Conceptual Orientation

The task here will be to use concepts, analyses and theoretical orientations which allow the identification of general patterns discernable in the arrangement of the relevant historical data,

yet also be able to preserve the sense of historical and sociological specificity of that data.

My conceptual and theoretical 'machinery' will be drawn from within general sociological theory and the sub-disciplines of the sociology of political power, professions, medicine, science, knowledge, religion and deviance. Theoretical and empirical work from these areas will be used to throw light upon the historical data relating to the relationships developed between regular and homeopathic medical practitioners and their institutions.

Working definitions of various terms will be given; terms such as 'profession', 'regular' and 'irregular' medicine, medical 'deviance', 'heresy', 'stigma'. The processes of 'stigmatization', 'marginalization', 'professionalization' and 'conversion' will also be explained.

Relevant work in recent sociology, history and philosophy of science will be incorporated in various ways to deepen our understanding of some of the phenomena discussed.

5.2. General Methodology

My methodology tries to be historically sensitive and sociologically self-aware. It is my aim to remain close to the approach which uses the sociological approach to attain an

historical objective rather than merely use historical evidence as illustrative of a pre-conceived sociological theory. This former approach was chosen because it stayed closer to the historians' concern with standards of craftsmanship in historiography. The illustrative approach tends to have an image of the historian as averse to theory in historiography and as a mere 'under-labourer' producing facts that the sociologist can selectively use to illustrate specific theories. Yet this is not to imply that the historically orientated sociologist cannot 'generate' historically adequate data and narrative accounts for more sociological purposes.

My object is not to produce an exhaustive Namierite historiographical narrative, nor some methodologically pure, integrated, 'grand' sociological theory. It is, rather, to address what are interesting problems and use the resources of historian and sociologist to mutually aid each other and provide adequate insights, descriptions and explanations.

The canvas is painted with both the broad strokes of the theoretical analysis of structural processes and detailed empirical events in order to bring out the long term developments and their more limited instantiations and contingencies.

6. METHODOLOGICAL ISSUES: Articulating a Critique

6.1. Standard History of Medicine

My approach is highly critical of the standard, or received historiography of medicine (S.H.M.). It seems to me that due to uncritically held positivist and whiggish notions about the development and change of 'scientific' (medical) knowledge, it more or less consistently and systematically ignores the historiography of unconventional, marginal, irregular or supposed 'pseudo-scientific' medical knowledge and practice. Because of these uncritically held assumptions about medical science, regular medicine's anti-quack ideology is also uncritically accepted - often as hidden theoretical 'baggage' - by the medical historian.

This S.H.M. concentrates almost exclusively upon the 'wonders' and precursors of 'scientific' medicine. Implicit in this received tradition was an image of the development of scientific medical knowledge as cumulative, linear, progressive and continuous. This is now held to be inadequate in explaining the marginalization of 'deviant' medicine. However, absolute discontinuity or incommensurability between medical paradigms or cosmologies is an opposite and equally erroneous position to take, even if the continuity thesis of the S.H.M. is questioned. I hold that there are both continuities and discontinuities between different phases of medical knowledge and practice, whichever period is chosen for study.

6.2. Internalist Historiography

I also hold that the deeper continuities are to be understood

more in terms of the nineteenth century regular profession's successful attempts at occupational monopolization within changing political contexts, rather than only in internalist terms of 'pure' medical knowledge and technical norms. This latter aspect is relevant and important but tends to produce only internalist history of medical ideas. Knowledge is more than just the epiphenomena of ideas. It is a socially produced and reproduced phenomena within settings of social and system interaction. I regard the traditional 'internal-external' dichotomy as a mere formal convention which obscures the actual relation between scientific knowledge production and the active role of the scientific worker in the whole process of the production of knowledge and ignorance.

6.3. Fact, Values and Social Pollution

Finally, the positivist 'fact-value' dichotomy is rejected for similar reasons. Social factors are not regarded by me as purely external or 'polluting' elements of true scientific knowledge. I regard such factors as constitutive of any knowledge system. Medicine seems to me an ideal strategic research site for the investigation of the relationship of 'scientific' knowledge, actual practices, occupational interests and the operation of mechanisms which set up boundaries between those medical systems which are taken to be true, good, sacred and pure, and those which are labelled as false, corrupting, heretical and polluting.

7. INTELLECTUAL RESPONSES AND DEVELOPMENTS: A Biographical Note

It would be useful for me to describe something of my own developing response to the kind of evidence I found, as I sought to understand the relationship between regular and homeopathic practitioners and endeavoured to develop an historical sociological approach to the materials I was dealing with.

7.1. Moralistic

This position was derived from an initial intuitive and affective response I had after preliminary research into the received history and sociology of (regular) medicine. Each received tradition had specific kinds of presuppositions embedded in their theoretical structure or narrative. These presuppositions were usually uncritically held to, and fairly faithfully reproduced, by the following generation of medical historians.

My impression was that the regular and dominant medical profession had systematically and successfully persecuted, stigmatized and/or ostracized any member of the regular profession who openly professed homeopathy. This had mainly been accomplished by the gaining of legal advantages from the polity, as well as carrying out an ideological campaign to successfully label the trained homeopaths as 'quacks'. From this picture of things I thought of the homeopaths as 'pure

victims'. As such they received extremely unfair and often immoral treatment from the regulars as regards the status and legitimacy of their supposedly 'heretical' therapeutic claims.

7.2. Medical Gangsters

This was a more rationalized version of the previous position and captured more of the politics and tactics of the organized medical profession/estates of the nineteenth century. In this sense it was a more dynamic model, yet the initiative and activism seemed to be all with the regulars, with the homeopaths still as 'pure victims'. This latter flaw was altered in a later position I developed (i.e. 7.4).

7.3. Witch-Hunt

In this the organized regular profession/estates were not just 'medical gangsters' but ones who legitimated what they collectively did and said with a certain kind of ideology. Part of this professional ideology was directed against 'irregular' and/or 'quack' practitioners. In a sense this ideology 'created' medical 'deviants' and medical 'heresy'. This reminded me of the Durkheimian thesis that Society 'creates', even 'needs', crime. Analogously, regular organized medicine 'created' irregular medical practitioners by collective self-definition.

7.4. Mutual Medical Mafias

Further historical research revealed that on one occasion,

in the U.S.A., the regulars and homeopaths had combined together to collectively persecute and stigmatize newly emerging 'deviant' medical groups; groups such as osteopaths, chiropractors and Christian Science faith healers. The regulars and homeopaths employed a similar anti-quack ideology against these 'heretical' groups as had been employed against the homeopaths by the regular practitioners earlier on. Thus, the notion of the homeopaths as 'pure victims' was eliminated. They were not only 'sinned against' but also 'sinned' in that they too were not averse to a medical 'gangsterism' of their own.

7.5. Theoretical Musings: Systemic Knowledge and Ignorance

Further reflection upon the processes of professional monopolization, marginalization and legitimation led to a consideration of a more general view of the occupational and ideological relationships between regulars and homeopaths. I think this view is applicable to other social phenomena where knowledge, production, reproduction and change are involved.

The sociology of (scientific) knowledge has traditionally concerned itself with the explicit content of configurations of knowledge and their relationship to social organization. Until recently it has uncritically accepted the ideological and normative assumptions of the positivist philosophy of science. This established an analytical and formal dichotomy between 'facts' and 'values'. It also demarcated what was 'internal' and

what was 'external' to scientific knowledge, as a system. This particular philosophy of science is no longer dominant and its dichotomies are only normative conventions rather than empirical descriptions of the actual practice of scientists. In the contemporary history, philosophy and sociology of science the agency of scientists within the scientific disciplines/communities is now regarded as crucial to the development of science as an enterprise. Scientific or technical decisions are made relative to some set of agreed criteria of adequacy, and implicit craft knowledge. Decisions to pursue, or not pursue, the solution of some specific set of problems, not only produce socially constituted knowledge but also socially constituted ignorance. Both are inherent features of social interaction and social systems over time.

If such decisions, based upon various kinds of evaluative criteria, determine what is to be counted as 'legitimate' knowledge then they also determine what is to be counted as illegitimate/pseudo-scientific/taboo knowledge. But if such decisions are taken when the objective intersubjectively testable basis is 'immature', i.e. when widespread, agreed, effective theoretical criteria, founded upon reproduceable experimental test situations are lacking, then knowledge may be ignored or excluded for a long time on the basis of social criteria alone. My contention is that this is substantially what happened to homeopathy during the nineteenth century in Great Britain and the United States.

This is in no way to imply a conspiracy theory as an explanation of the systematic production of knowledge and ignorance. It is, however, to positively claim that in the interaction of 'science' based (medical) practitioners, a significant motivating factor is if one group is dominant over another group but feels threatened by that group, then it will attempt to effect occupational closure. This produces the relatively effective monopolization of knowledge, practices and services relative to threatened livelihood. It is hypothesised that such a response tends to be more intense the greater the similarity in claimed or actual expertise, type of service, social role, occupational prestige, training, and type of organization, by the subordinate group.

The novelty of this approach to the standard conception of the historical and sociological relationship between regulars and homeopaths is that in each case the socially constituted features of their respective knowledge/ignorance systems are not produced by separate institutions, associations and social networks, but by the very same ones. That is to say that the organized regular practitioners did not have one communication and information system (such as a medical journal), to disseminate 'true medical knowledge' and another system to disseminate disinformation, caricatures and 'horror' stories about the homeopaths - the same system did both. The Lancet, British Medical Journal, Medical Times, Journal of the American Medical Association, British Health Journal and others provided

the medium for the production and reproduction of professional knowledge and ignorance about itself and those it labelled as 'heretics'. One purpose of nineteenth century regular medicine was the persecution, suppression and if possible, the elimination of medical 'heresy'. The homeopaths had their own counter system, of course. They had to, in order to survive such a concerted campaign against them.

RESEARCH SUMMARY

1. Research Areas

I propose to study the changes and developments within and between the regular medical profession/estates of the nineteenth century in the countries selected; the relevant changes in medical knowledge and practice; the interaction of regulars with professional homeopaths; the recent professional 'project' of occupational closure and attempts to monopolize the medical market place; the relation of that project to the marginalization and stigmatization of homeopathic theory and practice.

2. Homeopathy and Homeopaths

With this as necessary background knowledge we can then go on to investigate certain aspects of the development of homeopathy in the United States and Great Britain during the nineteenth century. We can also begin to understand something of the social and psychological factors which contributed to the conversion of some regularly trained practitioners to homeopathy.

3. Strategic Research Sites

The conflicts which arose between regulars and homeopathy provide strategic research sites to help make clearer the

social criteria and assumptions used in the 'stigmatization' of homeopaths by the regulars and the response of the homeopaths to this process.

4. Application

The critical implications of my research are then applied directly to the standard history of medicine with the aim of effecting a more sociologically and theoretically self-aware history of medicine, the research itself being a concrete example of this type of investigation.

CHAPTER ONE

1. MONOPOLIZATION AND THE ORGANIZED REGULAR MEDICAL PROFESSION: Its Development and Consequences

1.1. Introduction

The themes of 'professional monopoly', 'monopolization' and 'professionalization' have long been sociological concerns. Classical sociological writers - Durkheim, Weber and Marx - concerned themselves with the relation of professions to the social division of labour, status, class and power. Contemporary sociology has, until recently, occupied itself with problems of professional socialization, the 'natural history' of the development of professions, their traits and characteristics. The trait approach has been an influential one that uncritically accepted the self-definitions and self-characterizations of the professions (paradigmatically, medicine and law). Consequently, such an approach has tended to ignore historical and sociological specifics, such as the types of occupational organization and distributions of power within different kinds of professional association. Recently there has come about a re-emphasis upon the larger issues of the relation of the professions to internal and external power systems,(1) location within the class system,(2) and their role in the social mobility projects of 'professionalization'.(3)

When historians have examined the phenomena of 'the

professions' it has been handled in three basic ways. Firstly, as only a part of wider cultural continuities and transformations.(4) Secondly, as part of the process of some occupations (notably Divinity, Physic and Law), becoming 'professional' during the nineteenth-century in Britain(5) and the United States.(6) Thirdly, as historical studies of one profession only.(7) A similar situation has existed with social scientists.(8) However, there are those historians and sociologists who have tried to transcend the conventional intellectual and methodological barriers by working at the interface of the two disciplines - notably social historians and historical sociologists. This was done whilst preserving, or attempting to preserve, their own substantive disciplinary concerns and orientations to the empirical materials. Thus, they have produced sociologically informed histories(9) and historically informed sociological analysis(10) of the professions in general and the medical profession in particular, with mixed results. Some sociologists have proposed that because of the recovery of temporality in sociological theorising that it is valid to conclude that "history and sociology become methodologically indistinguishable"(11) [my emphasis]. This may indeed be so but it still permits the disciplinary styles emphasised in each approach to the empirical base of historical documents. That is to say, that in historiography the apparent non-theoretical narrative style predominates whilst in sociology, that of theoretical analysis,

abstraction and generalization are apparent.

1.2. Monopoly and Marginality

In order to more fully appreciate why, and how, what happened to the professional homeopaths[12] happened as it did, we need to be aware of 'monopolization' as a powerful explanatory thesis of such developments. It was not accidental that the regular practitioners, throughout their collective developments, were able to successfully delegitimate the homeopaths and their claims. This 'campaign' was able to deprive the homeopaths of, perhaps, the most prized and growing source of legitimacy during the latter half of the nineteenth-century - science.

What the regular, organized profession was able to deny the homeopaths - legitimacy - it was able to retain for itself and increasingly so as the end of the century approached. In order to dominate the medical market, the regular corporations, associations and institutions not only had to control the production of medical practitioners and their quality, but also control, eliminate, absorb or neutralize alternative competitors. If monopolization by the various sectional interests of regular medicine and development of the role of the 'professional' by the lower medical ranks was to succeed, the regulars had to control the production of practitioners and present a distinguishable set of goods and services. Also, as part of a collective system of domination, an anti-quack

ideology had to be largely believed in and acted upon by those same sectional interest groups. In short, homeopathy had to be successfully labelled as 'quackery' by denying its claim to legitimacy as 'scientific' therapy and valid medical theory. This would enable regular medicine to defend itself from the threat homeopathy posed to its own plausibility as the 'True' and the 'Good' medical knowledge and practice.

The legitimacy and scientific status of contemporary medicine is today an accomplished fact. How that 'facticity' was achieved in the face of considerable internal and external opposition enables us to throw some light upon the historical and social 'fate' of homeopathy[13] as a marginal medical system of thought and practice.

1.3. Some Misconceptions of the Monopolization Thesis

In some of its economic and sociological forms the monopolization thesis has often fallen prey to being presented by its advocates and interpreted by its critics as a thesis about '<u>medical imperialism</u>' and '<u>medical conspiracy</u>'.

1.3.1 Medical Imperialism

This has been a position employing a very value-laden critique of the medical profession and its development.[14] That is to say, the thesis refers to "the increasing and illegitimate medicalization of the social world".[15] Put very simply, the thesis of medical imperialism is a

sociological critique which asserts that we should never trust medical experts because they only want to extend expertise, tools, techniques and practices, as media of social control, into more and more areas of everyday life. This is done, it is argued, in order to exert increasingly ideological control over the consumer's choice of medical advice and therapy. By controlling the quantity and quality of 'legitimate' practitioners available, the established medical profession also guarantees its members a relatively lucrative livelihood. The existence of various medical institutions and the 'de facto' domination of many government investigative and educational medical councils and committees, provides the established profession with varied means of sustaining and extending its present monopoly.(16)

This thesis is employed by both liberal(17) and radical (often Marxist)(18) critics. The liberal offers it as a description and critique of the illegitimate medicalization of life and the increasing autonomy (and power), of the medical profession. The radical offers it as a description and critique of the inevitable consequences of state-supported health care within advanced capitalism.(19)

The advocacy of the 'monopolization thesis' within the aforementioned styles of 'prophetic' sociological analysis(20) is open to the basic danger of naïvety. Following upon this naïvety is the resultant danger of

exaggeration. This danger is increased relative to the intensity of political commitments that are in line with it. It is not to assume, though, that exaggeration is a logical consequence of the lack of critical self-awareness. Yet the less the historian/sociologist is aware of his/her interests in finding out 'nasty things' about medical practitioners and their institutions, the more likely that evidence to support this position is seized upon and contradictory evidence is ignored.

P.M. Strong[21] suggests six distortions due to the effects of naïvety on the part of those advocating the position of 'medical imperialism'. "First, there is a tendency to attack medicine with the benefit of hindsight."[22] This is done on the basis of too few empirical studies of the profession's attempts to medicalize further areas of everyday life. "Secondly, many of the critiques of medical imperialism lack any historical or anthropological awareness."[23] They often hark back to a non-existent "golden age" when medicine had not intruded itself into what was a 'natural' event or process.[24] Thirdly, that the medical profession is a single, unified, homogenous, occupational monolith. This ignores the various disciplines, sub-disciplines, political alignments and conflicting sectional interests that exist now and existed - in different configurations, of course, - in the past development of this occupation.[25] Fourthly, "a tendency to underestimate the technical success of

modern medicine".[26] Fifthly, "the misrepresentation of the extent to which a modern capitalist state can control medical imperialism"[27] especially the American version of that imperialism. Sixthly, and finally, "the notion of patient addiction to medicine is considerably overstated".[28]

The same author also cites certain inherent professional limitations that the thesis of medical imperialism usually omits to mention. First there are financial constraints. For example, the availability and status of medicine, especially from the general practitioner, expanded considerably with the creation of the Welfare State and the National Health Service in Great Britain. It was by no means a blank cheque for the medical profession. In America, medical welfarism was strongly resisted in order to retain the market conditions of practitioner control over the 'doctor-patient' situation. Yet, even this is open to a certain amount of 'interference' from (medical) insurance companies. In both situations the doctor-patient situation and the belief in the superior competence and expertise of the doctor in medical matters provided the bases from which the medical profession could effectively defend itself from too much interference by third parties. At least that is so in the United States and Great Britain even if not so in Europe generally.[29]

Second, there is the central concern of professional practitioners with "biological matters which are at one and the same time both technically complex and susceptible to practical intervention"[30] and which are therapeutically and financially cost effective. That is to say, the modern doctor is concerned with the therapeutic success and fundamental knowledge of human biology.

Third, the professional organizations also impose restrictions on the expansion of medical practices and practitioners by controlling the numbers (and quality) who actually enter the profession through the means of certification and licensing. Too many doctors in the professional marketplace are a threat to individual income and career. Yet it can be noted that "doctors have managed to expand their empire, while at the same time severely restricting the production of new doctors. This has been achieved by the expansion of the 'paramedical, or ancillary medical professions' which have been delegated some of the doctor's old tasks yet still remain firmly under medical control..... without at the same time threatening the doctor's status. Indeed..... it has in many ways reinforced it."[31] However, the existence of welfare professionals and the extension of welfare bureaucracy may well impose external limits to the expansion of the 'medical empire'.

Lastly, the doctors may have monopoly of legitimate

practice but that does not mean it can totally constrain patient behaviour. There are 'alternative' medical practitioners, some licensed (like the homeopaths in Britain; homeopaths and osteopaths in the United States), and some not, e.g. chiropractors, naturopaths and other marginal/fringe practitioners.(32) There is also much self-help medicine practiced by ill people in their families which is outside professional social control. However, the existence of the right of the patients to choose what kind of treatment to receive or choose to receive no treatment at all, provides some incentive for regular practitioners to seek greater relative medical monopoly.

In conclusion, if we are going to discuss 'medical imperialism' we should apply it to <u>all</u> the professions/occupations seeking to dominate their market and/or control the quantity and quality of their supply of practitioners. We should bear in mind the exaggerations such a thesis can produce, especially if held to rather naïvely. Lastly, we should not be ignorant of the internal and external limitations constraining medical expansion and domination.

1.3.2 <u>Medical Conspiracy</u>

This interpretation of the 'monopolization thesis' is not necessarily directly stated by writers, liberal or radical-Marxist. It tends to be communicated in terms

of the style and tone of the writer. It is suggested more by implication rather than by explicit statement. 'Conspiracy' has the flavour of a secret plot for evil and/or illegitimate purposes. This is not to say that some sections of the medical practitioners, such as leaders of medical corporations, did not plan, set aims, objectives or ideals for themselves and others.However, this is hardly a 'conspiracy' in the sense often implied. It is an activity that occupational, organizational and intellectual 'leaders' engage in as normal everyday practice in pursuit, or defence, of certain sectional interests.

In the struggle to 'professionalize' medical practice by raising the income and the status of a wider community of medical practitioners, monopolistic policies were used. Briefly, monopolization was, and is, an attempt to reduce the unpredictability of the market and raise the incomes of practitioners.(33) By linking this with educational reform and licensing control the medical corporations were able to steadily improve the quality and competence of the average practitioner. This was done in order to justify the necessity for market controls, backed by legislation designed to regulate work-task boundaries. At the same time the sectional interests, privileges and status of the separate corporations were preserved(34) or even improved(35) in the long term.

The monopolization thesis I formulate will attempt to steer clear of the implications of these two distortions as far as is possible. However, that does not mean that we cannot write of monopolization as incorporating a conception of 'collective' or 'sectional interests', (see below), which will enable us to make sense of the notion of 'professional project' in relation to the occupational processes of 'closure' and 'market control'.

1.3.3 Collective/Sectional Interests

Social and political thinkers alike have been divided over the relation of 'the individual' to 'the collective' or 'society'. This has been argued at the levels of social theory and methodology. Those who advocate methodological individualism argue that in social theory description of social wholes and collective interests can/must be reduceable to terms of individual attitudes, decisions and actions.(36) In short, a kind of psychological reductionism is practiced. Those who advocate methodological collectivism argue that system properties are not reduceable to individual action, nor is the sum total of individual action (a sort of social arithmetic) an adequate explanation of certain collective phenomena or 'emergent properties' of social systems.(37) Yet so often this position arrives at a form of sociological reductionism which theoretically annihilates the acting subject as an individual and as a person. If the subject does exist

it is only as a 'happy robot' with 'Society' pulling the strings of social action.

These opposed positions are both inadequate. 'Individualism' lacks an adequate theory of institutions and social systems. 'Collectivism' has an inadequate theory of human agency and its relation to patterned interaction over time.(38)

It seems to me that with the recent work of Anthony Giddens(39) a significant breakthrough into a more adequate conception of social agency (individual and collective), and social action is now possible.(40)

Relevant to us is the concept of (sectional) interests Giddens develops.(41) He argues that "Interests presumes wants, but the concept of interests concerns not the wants as such, but the possible modes of their realization in a given set of circumstances."(42) Previously, 'interests', 'wants' and 'needs' had been wrongly attributed to the structural properties of social systems and even been combined with a notion of the teleology of social systems. This anthropomorphized the concept of societal development and differentiation by combining it with a concept of functional imperativism.(43) Yet a sociological conception of 'interests' can be retained, argues Giddens, for "Nonetheless, actors have interests by virtue of their membership of particular groups, communication, classes, etc. This is why it is so important not to treat wants

and interests as equivalent concepts: interests imply potential courses of action, in contingent social and material circumstances".(44) This enables us to avoid imputing teleological imperatives, to the processes of medical monopolization. Teleology only exists, in a social system or collectivity, at the level of the individual agent's interests and objectives. Yet neither do we have to conceive of a social agent exclusively in terms of individual human actors. A social agent can be corporate and its leadership can usually be taken as fairly representative of its (active) members' interests. In that sense, a 'collectivity' can be said to have 'collective interests', even if they are only the sectional interests of a leadership or power elite. How representative those sectional interests are of the 'collectivity' is relative to the kind of distribution and organization of power, authority and decision-making apparatus and member involvement there is.(45)

Mogali S. Larson's notion of the collective project of professionalization(46) comes closest to Giddens' sociological conception of 'collective interests'. Larson notes (47) that as currently used in sociological analyses the term 'project', i.e. a planned undertaking, does not necessarily refer to conscious, deliberate or clearly planned strategies of action by certain groups to achieve specific goals. [However, that may be the case with certain groups small enough for continuous face-to-face

interaction.] It rather refers to the consequences of a given course of action. Methodologically it indicates the coherence or consistency discoverable, with hindsight, in a variety of seemingly disconnected empirical acts and events.

I would want to note that the action of agents are never totally disconnected. They are continuous and connected flows of conduct in time and space.(48) Neither are social events disconnected. They must be caused by some prior event(s) and they have consequences, intended and unintended. It is not clear if Larson does, in fact, include in the concept of 'consequences of a given course of action' both intended and unintended consequences.(49) If not, then we need to include both in our concept of monopolization when using it as an heuristic device to describe various strategies employed to effect occupational closure and/or market domination through monopolizing practices.

1.3.4 Review

I have sketched two of the basic pitfalls that the monopolization thesis should avoid . First, that the notion of medical imperialism, as extension of the 'medical empire', does not have to carry the stigma of ontological evil or moral illegality. Thus without such connotations we can still appreciate the fact that in Britain and the United States a specific set of practitioners have extended their

domination and control of the medical market by definite means. Even though these practitioners[50] were in conflict with each other they were able to expand their domination through negotiation, compromise, conflict and benign non-decision when dealing with each other or the government's administration. They dealt with their irregular competitors by direct confrontation, some official co-operation (U.S.A. only), absorption, 'neutralization' and 'stigmatization'.[51]

Second, that there is no good reason to assume a medical conspiracy by the medical professions 'en masse' in order for monopolization to occur. Medical leadership pursued specific sectional interests to achieve certain occupational goals, e.g. reform of medical education. Monopoly was not 'accomplished' by any 'evil conspiracy' of medical elites working behind the scenes against the wishes of the mass of regular practitioners, government or public. Yet this is not to ignore the fact that the policies pursued by the regular medical profession (for the highest and noblest of reasons, of course), had intended and unintended monopolistic consequences for the public generally, the irregular practitioners and themselves in particular.

Lastly, I put forward a conception of sectional interests which avoided imputing 'wants', 'needs' or 'interests' to social systems. Yet it would still allow us to conceive of such interests in terms of the attempts to realize

"potential courses of action, in contingent social and material circumstances".[52]

Bearing these points in mind we can now briefly delineate the contents of a thesis of medical monopolization specifically fitted to the British and American situations.

1.4 The Thesis of Medical Monopolization in Historiographic Outline

This thesis refers to the capability of the 'regular' or 'mainstream' medical practitioners[53] to come to successfully dominate the medical marketplace by providing significant and identifiable goods and services; to effect occupational closure in relation to irregular or alternative practitioners by depriving them of widespread social, economic, political and intellectual resources and legitimacy; to control the production of practitioners in terms of their quantity and quality by establishing criteria of entry and certification of competence; to gain, retain and/or extend the legitimacy of the profession's regular practitioners and practices by securing advantageous legislation from the polity, particularly in terms of licensure. The specific extent and quality of this capability is contingent upon a complex constellation of variables - ideological, legislative, sociological, technical, intellectual, institutional and political.

In Britain it began with the securing of formal crown patronage for the establishment of a metropolitan college

of elite physicians in 1511. This gained administrative effectiveness in 1518. In 1523 this elite college of practitioners was able to shift the basis of its patronage and legislative advantages from the Crown to the more stable legitimating support of Parliament. It employed a 'professional'/'national service' ideology to gain political legitimacy just as Parliament had done on a prior occasion in order to legitimate itself in relation to the Monarchy. This move, in its legitimating social basis and ideology, extended its monopolistic jurisdiction from within the seven-mile radius of the City of London to the whole of England. In a strong sense the Royal College of Physicians was the beginning of an increasingly institutionalized but limited solution to the perennial problem facing any group of occupational practitioners claiming legitimate 'professional' status and/or monopoly of expertise - how to earn a livelihood in the face of competition from other practitioners. In point of fact, the Royal College of Physicians was unable to suppress irregular practitioners, since the general public, especially the lower orders, just could not afford the physicians. Regular physicians were perceived as providing therapies which were no more adequate than those of the irregulars yet cost much more. Indeed, my case is that the adequacy and effectiveness of regular <u>therapeutics</u>, in the sense of curative intervention, through means of drugs,[54] did not, and could not, occur, on a scale applicable to "the public" en masse,

until 1892, with the use of diphtheria antitoxin discovered by Behring. This was a product of the bacteriological revolution that reached 'take-off' with the exemplary research of Robert Koch during the early 1870's which was published in 1876.(55) Many physicians were involved in public health reforms throughout the nineteenth-century and surgery was transformed from a brutal craft to an exemplary medical science by anaesthesia and Listerian antiseptics during the 1850's to 1880's. However, the provision of actual drugs that could cure the victims of epidemic diseases such as cholera, yellow fever, diphtheria and typhoid; and endemic diseases such as malaria, dysentery and pneumonia, were very few and certainly not consistent. Often they were more palliative than curative and for much of the nineteenth-century most active intervention by regular physicians was non-curative at best, positively harmful at worst.

During the late eighteenth - and early nineteenth-century in the United States there was a certain amount of control by the regulars at the State and local levels through legislation secured by the medical societies. This was lost during the 1830's and 1840's, the era of populist Jacksonian democracy.(56) Although a national medical association, the American Medical Association, was created in 1846/7 to try to improve the status and quality of the regular medical profession and combat irregular practitioners, it had no real lasting success until about the

mid-1870's but particularly from the 1890's onwards.[57] This was due to three processes converging in the last third of the nineteenth-century.

First, there was increasing success by the regulars in setting up state examination and licensing boards through the activities of the American Medical Association and local medical society lobbies. Their purpose was to gain licensing advantages by taking this function out of the hands of the medical schools and their diplomas and placing it in the hands of seemingly 'neutral' civic licensing authorities. These were, de facto, controlled by regular practitioners. "In 1888 only five states required such examination; by 1896 eighteen others had amended their laws in the same way".[58] However, by the 1890's the homeopaths and eclectic physicians had their own state examination and licensing boards too. Each board had a separate examination in their own therapeutic approach but with common examinations in anatomy, surgery, physiology and other basic biomedical disciplines.

Second, reform of medical education had occurred only spasmodically and very slowly during the 1850's to 1870's. This was radically changed by the establishing of an exemplary university medical education independent of student fees.[59] The financial base for such a university with its own medical school and hospital, was provided by the banker, Johns Hopkins (1795-1873). Work began on The Johns Hopkins University in 1876. The Medical School

facilities and curriculum were modelled upon the German type of medical education, with a four-year graded curriculum, preclinical laboratory training and a clinical teaching hospital. Its teachers were not drawn from the immediate locality as was traditional but from the nation as a whole.

The period 1870 to 1914 saw many ambitious young American physicians doing post-graduate work in Germany. They returned home to add their voices to the demand for complete reform of American medical education. The Johns Hopkins was the first thorough-going American version of this demand and vision. Between 1890-1910 the success of the Johns Hopkins became the symbol for national reform, this time successful, of the medical colleges. It culminated in the Flexner Report of 1910 by which time a "national cartel" of regular medical organizations had been formed between the American Medical Association, the American Association of Medical Colleges, the National Confederation of State Medical Examining and Licensing Board and the emerging 'Germanized' university medical facilities. Thus 'Flexnerization'[60] pushed the reform of medical education even further and laid the basis for a national, standardized system of medical education. It also meant the demise of many medical colleges, thus leading to a scarcity of trained physicians and an even greater concentration of specialists and medical resources in the

urban centres.

Third, the rapid and increasing diffusion of innovations in medical knowledge, tools and techniques brought increased expertise and specialization during the last third of the nineteenth-century. National universities took up research into basic biomedical sciences in a systematic, programmatic way, with 'big-money' to help them, from the State (as in the United Kingdom), or philanthropists (as in the U.S.A.).

So far I have given a summary historical outline of the monopolization thesis as applied to the regular medical profession. I have sketched in some of the pivotal historical trends which promoted the interests of the regular medical practitioners towards increasing domination of the medical market through three processes. First the increasing 'scientification' of medical knowledge and practices. This enabled identifiable goods and services to be produced which became more and more efficacious, especially with the creation of bacteriological-laboratory medicine. This had become the ruling conceptual scheme and research programme by the 1890's with its immediate roots regarding effective therapy in the work of Robert Koch during the mid-1870's.

Second, I have noted the crucial role of effective and enforceable licensing legislation. This provided a basic legitimation for the regular medical profession and its

practices. It also set up formal group boundary criteria. However, in Britain the licensed homeopaths were able to retain a place within the regular profession, although a minor and marginal one. In the United States the professional homeopaths (those with training in regular medicine plus training in homeopathic therapeutics and materia medica), were essentially kept external to the regular practitioners and their institutions. Formal scientific legitimacy has been denied British and American homeopaths to this day.(61)

Lastly, I have indicated the radical effects of an effective reform of medical education linked to an emerging national education system, especially at the university level. For it was here that both standardized scientific medical knowledge and regular medical practitioners were produced. Thus, the university of the late nineteenth-century became the key to the production and standardization of medical knowledge and medical practitioners along contemporary lines.

The cumulative effects of these key developments was the decimation of homeopathic medical colleges in the United States. In both Britain and the United States there were increased difficulties of recruiting qualified practitioners to a homeopathic practice which was even more marginal at the close of the nineteenth-century than when it began to take institutional root during the 1830's onwards.

1.4.1 The Monopolization Thesis as an Ideal Type

The contemporary notions of monopoly and monopolization have their roots in economic theory regarding the kinds of systems produced by specified market conditions of competition, or its absence. This has produced two ideal type models of market behaviour. One is that of Perfect Competition and the other is that of Pure Monopoly.(62) Since pure monopoly is an ideal type construct we must note that it is an analytical tool only. As Max Weber said, "An ideal type is formed by the one-sided accentuation of one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present and occasionally absent concrete individual phenomena, which are arranged according to those one-sidedly emphasized viewpoints into a unified analytical construct. In its conceptual purity this mental construct cannot be found empirically anywhere in reality. It is a Utopia. Historical research faces the task of determining in each individual case the extent to which this ideal construct approximates to or diverges from reality....."(63) It refers neither to moral ideals nor to statistical averages. It never corresponds to a single concrete social reality although it is an abstraction of certain concrete elements from general types of phenomena, like bureaucracy. Being an abstraction, the ideal type of "medical monopoly" provides a conceptual device with

which Weber claims we can compare empirical developments and clarify the important aspects of that empirical reality. In short, 'pure medical monopoly' has not yet been observed (nor is it likely to be), by sociologists, historians or economists. Yet it is still worth claiming that the empirical development of the occupation of regular medicine has approximated to this type in varying degrees. The two key elements being the degrees of market control and occupational closure exercised by the regular practitioners through their regulatory associations and educational establishments.

1.5. Basic Elements of Medical Monopolization

I will now briefly set out the main factors whose presence or absence are variables in the establishing of effective medical monopoly. Some of these factors will be explained in some detail since they are key variables whose presence constitutes the necessary (but not sufficient), conditions for successful monopolization of the medical market and occupational closure. With hindsight we can strongly argue that "medical professions..... have developed a variety of tactics for domination on behalf of monopolization..... They have constructed most of the rules for the regulation of economic conduct on the part of professionals..... They have established varying degrees of domination over both the medical market and the modern legislative institutions of the State."(64)

These conditions and strategies are as follows.

1.5.1 Autonomy

This is a sustained institutional, ideologically legitimated, occupational independence - from third party or client intervention; in the doctor/patient relationship; in the status of medical knowledge and practice; in medical decision-making and practitioner competence.

This condition is, of course, historically relative to the type of occupational control practiced within the medical institutions. Particularly important are the producer/producer, producer/client relationships and the control of credentialing and licensing. If the medical profession has effective control/domination of these areas then an ideology regarding its autonomy which 'resonates' with the wider prevailing political ideology is almost sure to be accepted by the public and the polity. If its knowledge and theoretical system is sufficiently abstract, esoteric and yet standardizeable, then it has the power to determine the scope of its services, what constitutes a client's medical 'problem' and 'solution' of that problem. Because of this claim to relative cognitive exclusivity it also has power to control the technical extent of medical practice and so extend its competence into previously unmedicalized areas of ordinary life, e.g. treatment of alcoholism as a 'disease' rather than a moral failing.

With a monopoly of competence it also has the capability to dominate an area of the division of labour and through that the medical market place.(65)

1.5.2 Distinctive Commodities and Standard Services

Professional medical services are presented as 'commodities' within the doctor/patient context, normally on a "fee for service" basis. The cash nexus of this relationship is now modified by various kinds and levels of intervention by the State. However, much of the doctor's commodity is intangible in the sense that it is not an invariant product of an invariant and specific set of operations upon specific materials as in a factory system of production.

To establish a degree of consistency regarding these services the practitioner receives some kind of education (formal and/or apprenticeship), which is more or less standardized. This enables the services of the regular practitioners to be clearly differentiated from those provided by irregulars and/or 'quacks'. Yet if the degree of standardization is qualitatively poor then competition from irregulars and/or 'quacks' can pose a serious threat to the livelihood, social and intellectual plausibility of regular practitioners. The homeopaths in Britain and the United States posed such a threat between the mid-1830's to about the early 1880's. After this period they rapidly

declined as their own raison d'être was undermined by the transformation of regular medicine from a therapeutically sceptical, clinical, hospital-orientated medical system to that of the increasingly therapeutically effective bacteriological-laboratory medicine of the late nineteenth-century. This provided the new conceptual core for both public health reform and the innovations being made in therapeutic practices, available to general practitioners, surgeons and other medical specialists.

In short, the historical and corporate development of the regular medical practitioners saw the monopolizing capability of that collectivity being increasingly enhanced as the commodities,services and practitioners became progressively standardized, yet more distinctive and effective in their set of medical practices, tools, techniques and methods. This capability was greatly improved as legislative advantages increased, basic biomedical research became increasingly relevant to medical practice and livelihood, and this knowledge was more and more only accessible by means of a formal college/university education. Such an education became part of an educational system increasingly national in scope and organization. This process of cognitive standardization and its relation to market control will be expanded on considerably in a later section, (i.e. 1.8 to 1.8.3.).

1.5.3 Eliminating Irregular Competition

As a direct result of standardization and specialization of professional medical services, there is an increasing "tendency to monopoly by elimination of competing products.. ..... for if other standards of evaluation were allowed to prevail the preference of the public could not easily be reclaimed away from older consumer loyalties".(66)

This applies to different kinds of monopoly - restricted or extended, inclusive or exclusive. For example, the early Royal College of Physicians exercised a local, restricted and exclusive monopoly within a seven-mile radius of the City of London between about 1518 and 1523. In 1523 it managed to shift the basis of its legitimacy from the arbitrariness of the Crown to the less arbitrary one of Parliament. In so doing its jurisdiction was extended to the whole of England. Although more national in scope, its control still remained in the hands of an exclusive 'Oxbridge'- trained elite of gentleman physicians.

During the professionalizing project of the upwardly mobile provincial and corporation non-elite members, the reforming practitioners (in order to maintain and extend their market control), had to engage in the ideological task of establishing in the 'lay' consciousness a common basis for the evaluation of the need of professional services and competence. This, however, could not be

done purely by the effort of the regular practitioners alone. It had to wait upon the completion of the general societal shift to a new symbolic social and economic universe,[67] - the product and basis of this was the European Industrial Revolution established in the late eighteenth-century.

The elimination of external, irregular competition could occur once a sufficient occupational and membership closure had been achieved. The creation of "in-group/out-group" boundaries in order to do this was not an easy task, especially since the services and commodities of the regulars was not sufficiently distinctive or effective in comparison to those of the irregulars. This was so for a good two-thirds of the nineteenth-century in the U.S.A. and Britain. The history of the Thomsonians, Eclectics and Homeopaths in the U.S.A. and the homeopaths, hydropaths, mesmerists and various others, in Britain during the first half of the nineteenth-century seems to bear this interpretation out.[68]

In the medical journals these irregular practitioners were perceived as comprising somewhat of a 'medical triumvirate of evil' in their respective nations[69] against which the regulars claimed to contend with 'scientific method', 'rational argument' and 'professional experience'. In their rhetoric the regulars used a great deal of abuse to stigmatize their irregular medical

opponents. The intensity of this rhetoric is some evidence of the real threat posed to the socially grounded plausibility structure of the regular medical cosmology.

In order to eliminate irregular competitors in an efficient and effective way, membership closure has to be achieved (see 1.5.4.), in order to make it in their interests to do it. The regulars typically claimed to supply the only genuine, effective medical commodity. Concomitantly they declared all others as 'quacks', 'charlatans' and 'unscientific'. This construction of an anti-quack ideology organized around emotionally loaded language and imagery effectively stereotyped the non-regular competition. Typically, stereotyping functions at a non-rational affective level in the human mind. It results in the ignoring of fine distinctions, counterevidence, and reasoned refutations of its claims. It regards as 'evil' and 'taboo' the beliefs and practices of these irregulars who constitute 'the enemy'[(70)], even and especially , in the face of valid criticisms of 'orthodox' beliefs, practices, tools, techniques and therapies.

Part of the efforts, by the regulars, to put the irregulars out of business and out of their own ranks was manifested by the constant battles they fought to gain legislation favourable to their own interests. This attempted elimination of irregular competition was not possible without the employment of two basic strategies.

First, the ideologically conditioned ethical claims in favour of their own services, practices and knowledge; with counter-claims against the competitors. The purpose of these claims was to gain and/or maintain their own legitimacy and to deny, undermine or eliminate any legitimacy claimed by the irregulars. These legitimacy claims were aimed at the public and their own members in order to gain popular recognition and acceptance of them.

Second, the gaining of advantageous licensing legislation in order to focus the power and prestige of the political community against the competitors. This was achieved very effectively by the medical corporations in Britain through a series of medical bills which culminated in the 1858 Medical Act. However, this Act did not result in the casting of the qualified homeopaths into the 'outer darkness' of the medical fringe cults because the homeopaths were able to mobilize their patrons, inside and outside Parliament, to finally have the offending parts of the Bill amended in their favour. After these amendments were made, all duly certificated doctors could be registered and later licensed. However, they could not be <u>made</u> to practice regular medicine or any other form of medicine if it was against their conscience to do so, Thus professional homeopaths were very much like their regular equivalents in terms of education, examinations passed, registration and licensing - except that they chose to

practice homeopathic materia medica and therapeutics, after suitable training.

The second of these strategies has been by far the most reliable and effective compared to the attempts to gain popular recognition and popular legitimacy. Why? Simply because the gaining of licensing advantages does not require "widespread acceptance of the validity of legitimacy claims to eliminate external competitors".(71) Acceptance of ethical claims of validity and legitimacy by the public requires a lengthy ideological campaign that has a poor chance of success since it has to win over the public to the claims of the regular practitioners.

1.5.4 Unification of Suppliers

"The members of a monopolistic service group are economically rational if they behave as though they were, collectively, a single supplier. Co-ordination requires the development of a sense of mutual interests, group identification and the creation of a system of group controls to ensure equal pricing..... The individualizing tendencies of economic interest, therefore, require a certain measure of balance by appeals to integrative economic rationality, moral duty, technical rationality or by coercive means in the form of ostracism or expulsion."(72) Indeed, the different sensitivities of regular practitioners to appeals regarding the long-term economic benefits of the profession leads

them to being framed in the language of appeals to professional solidarity, co-operation, etiquette and social status. The function of the creation, diffusion and enforcement by consensus of medical ethics is quite crucial in this process of unification of the suppliers of (regular) medical services. Medical ethics function to reduce practitioner conflict within the profession as a counter to individualistic competitive economic behaviour. The paradigmatic example of such a functioning code of medical ethics and etiquette is that formulated by Thomas Percival (1740-1804). This English code eventually formed the general basis of the regular physicians 'professional' behaviour, and was later exported to the United States where the American Medical Association modified it for its own purposes.(73)

For the unification of suppliers to be successful, in relation to control/domination of the medical market place, certain other things also have to happen.

1.5.4 (a) The Restriction of Group Membership and Occupational Closure

This is a necessary condition for the creation of an occupational monopoly. Such closure refers to "the possibility of some groups dominating and controlling the market for the services they provide".(74) Indeed, occupational closure legitimated by an ideology of 'professionalism' and a certain set of actual or attainable institutional arrangements constitutes a process whereby

social class and social status are linked in order to achieve closure.[75] Also, occupational closure is part of a wider process of 'social closure' which is "the process by which social collectivities seek to maximise rewards by restricting access to rewards and opportunities to a limited circle of eligibles".[76] Thus:

"Closure is concerned with the exclusion of outsiders usually from specific economic opportunities which the eligibles wish to keep to themselves".[77] Two types of social action to achieve social closure have been recognised - exclusion and solidarism.[78] However, these are not mutually exclusive modes of social closure. Exclusion is not confined to the traditional/classical professional occupations of medicine, law, or the ministry. Neither is solidarism confined to trades unions of the craft-guild type, as Frank Parkin (1974), maintains.

"The relationship between the relative success of exclusion practices and the reaction of the excluded is fundamental to an understanding of collective social mobility. Upward collective social mobility is dependent both upon the existence of appropriate aspirations in an excluded group and their ability to organize themselves for the purpose of breaking into and assimilating with a higher status group from which they are excluded."[79] The long battle for medical reform that the general practitioners (apothecary-surgeon) were engaged in for most of the first half of the

nineteenth-century in Britain is a fine example of the reaction of an excluded group to the restrictive monopolies, status and privileges exercised by the traditional corporations of the Royal College of Physicians, the Royal College of Surgeons and Apothecaries Hall, in London.

As I said beforehand, exclusion and solidarism are not mutually incompatible forms of social action. Solidarism can be used effectively by and amongst..... "those who also have other resources with which to follow strategies of exclusion and closure such as those of a credentialist kind".(80)

Indeed "credentialist" strategies, focused around claims of monopolies of competence and/or demands for reform of medical education to improve the standards of medical practice, have been used most effectively by the medical estates of nineteenth-century Britain in a two-fold direction. First to clearly differentiate qualified from unqualified practitioners and second as a means of upwardly mobile medical practitioners, e.g. apothecary-surgeons/general practitioners, to undermine the traditional medical hierarchy which excluded them. This was in order to create the occupational social 'space' necessary to achieve comparable status with the physician elite. In Britain this medical reform movement eventually broke down the traditional tripartite medical hierarchy of physicians, surgeons and apothecaries and their corporations. This new

hierarchy was organized around access to hospital-based resources and career structures rather than around the status dichotomies of the 'gentlemen', 'professional'/ 'craft' occupations of the tripartite medical system which depended upon access, or not, to elite patronage.

Occupational membership restrictions serve the interests of the group in many ways. For example it makes professional services scarcer thus decreasing supply relative to demand and raising the prices of those services independently. Such scarcity has conventionally been created <u>either</u> through decreasing the supply by reducing the availability of the services as a commodity in the medical market place, (traditionally achieved by controlling licensing, access to which is only possible through a system of education, examination and certification), <u>OR</u> by increasing the demand for the services by upgrading the quality of the commodity and increasing its marginal utility in relation to competing products, (educational reform has classically achieved this). Often the two are combined so that.....

"In the case of the medical profession, scarcity has been most effectively achieved by <u>both</u> reducing supply <u>and</u> increasing demand through the same institutional mechanism: <u>licensing</u>".(81)

1.5.4 (b) Increase of Group Solidarity, Co-operation and Membership Loyalty

This is accomplished through two means. First, by the purely rational economic calculation in terms of the increased income possible in the same market, and second, by the increased non-economic, social and emotional ties of friendships, association and acquaintance which help to integrate a group over and above that which rational calculative means can ever achieve. Such cohesion should not be equated with a monolithic consensus and uniformity of values, attitudes, ideas and behaviour. It simply indicates the advantages that co-ordinated collective action has in relation to the achievement of a specific group's collective interests. Group cohesion of this economic-affective type performs certain functions to the advantage of the group. It discourages the public display of conflicts and disagreements between group members due to the individualizing effects of economic competition within the profession. Codes of "medical ethics" are the formal expressions of this recognition to reduce intra-professional conflict and regulate professional relationships. Such codes not only generate the social practices of the profession but are also constituted by the production and reproduction of such practices. These ethical codes can be more formal expressions of what already generally occurs at an implicit and tacit level of social practice; or they can express that behaviour which the best practitioners already

engage in. All that I need to say is that such 'rules' are at one and the same time constitutive and regulative of the same social action. 'Rules' are not fixed or inviolable since, "The operations of practical consciousness enmesh rules and the 'methodological' interpretation of rules in the continuity of practices".(82)

That is to say that ethical codes are produced by, and producers of, social practices which are constantly being produced and reproduced, negotiated and re-negotiated in the ongoingness of agency interaction, (whether that is the social individual, or a collectivity with leaders representing members' interests). Cohesion and co-operation increases behavioural conformity to the group norms. Such conformity is always in relation to a range of acceptable medical beliefs, practices and 'professional' behaviours that any duly trained and certificated individual can hold to and engage in. Such relative conformity is rewarded subjectively through the sociabilities of participation in member activities, friendship of colleagues and so on.

It also predisposes members to protect each others interests when criticized adversely by non-members.

Also, if there exists a system of differential supply within the group, such as consultant referrals, then members are predisposed to 'arrange' to help each other obtain 'customers' for their services.(83)

Lastly, it predisposes members to further the interests of the collectivity rather than just their own personal interests.

1.5.4 (c) Occupational Ethics and Control of Practitioner Behaviour

The regulative effects of the enforcement of a particular ethical code has routinely been the means of discouraging intra-professional competition through undercutting other practitioners: "The organizational principle that economic competition prevents successful price fixing leads to efforts among group members to curtail intra-group competition".(84)

Other competitive practices such as advertising one's medical services (a form of competition for patients), or bargaining with patients, have also received routine moral condemnation. Such kinds of competition have often constituted grounds for expulsion from medical societies, whether regular, or irregular,(85) and even the "legal revocation of a licence to practice".(86)

There is a certain irony in the denouncing of competitive economic behaviour as being merely material acquisitiveness and yet, in fact, the enforcement of non-competition between regular practitioners has actually brought in greater material rewards, in the long term, for all members. When internal competition is suppressed and external competition is successfully persecuted, stigmatized or otherwise rendered illegitimate and marginal;

when there is relative control of educational input, then prices can be fixed relatively independently of the market. Of course, price limits continue to exist since it is not rational to price oneself out of the market.

"It is in the interest of group members to reject competitive pricing in favour of price-fixing in order to maximize total group income."(87) Such a position has been moralized at times by including fee tables within the formal code of medical ethics as happened with the American Medical Association's 1912 code. Yet, "Price fixing recast in moral terms remains price fixing."(88)

1.6 Intended and Unintended Consequences

The components of empirically accessible monopolistic processes in the development of medicine, in nineteenth-century Britain and the United States, have all been partly premised upon the important condition of the eventual acceptance, by the lay public, of the legitimacy claims of the regular organized medical practitioners and hence the general implicit rejection of alternative/irregular practitioners. The claims to professional status were made by all the medical orders in varying degrees of intensity. This aspect of professionalization includes claims to professional autonomy, monopolies of competence, ethicality, social and cognitive exclusivity, 'scientificity' and public service. These claims are well documented by historians of medicine, but as to their significance and

meaning the same historians differ but not in diametrically opposed ways.

Each of these claims, when acted upon in specific contexts, has determinate consequences. At the level of individual human agency, whose chronic feature is the reflexive monitoring of action and its rationalization, social action occurs within the context of the unacknowledged conditions of action and issues in both intended and unintended consequences.

In short, what people individually or collectively claim to be the 'natural' and intended consequence of their action is really only part of what does actually result, since actions also have consequences which constantly escape the intentionality of the agent.

A sociological perspective on agency, interests, motivation and consequences of action is directly relevant for my notion of monopolization as an historically developing process. Its present shape and extent is a product of both the intended and unintended consequences of the activity of agents, (individual and collective), over time.

As I have indicated before (see section 1.3 - 1.4), medical monopolization is not necessarily linked to any medical conspiracy based upon the sectional interests of an imperialistic medical elite, but it does have an empirical link with the pursuit of occupational closure. Those

consciously sought goals to create exclusivist, institutionalized group boundaries; to promote, defend and extend sectional interests; to dominate the medical market place through the quality control of regular medical practitioners (via licensing and educational reform), all were still clearly present in the responses of regular practitioners to the conditions of their occupation, its organization, institutions and policies throughout nineteenth-century Britain and the United States. Nor is the monopolization process a cumulative, uniform process unfolding in an inevitable sequence of developmental stages according to some intrinsic, inherent, impersonal, passionless logic which sweeps all before it. Nor is the medical 'professionalization project', i.e. to try to control markets and improve their status, necessarily applicable to other periods, societies or occupational groups.(89) Nor is the seeking of market control and improved status peculiar to the medical practitioners of the nineteenth-century. Nor did a monolithic consensus of opinion within the medical profession exist regarding a 'common project'. What is claimed is that monopolization, although exhibiting a variety of historically specific forms and contingent upon the occurrence of their conditions for its extension or otherwise, does exhibit determinate, specifiable and humanly organized elements that are reproduced from age to age, although in differing configurations and under different systems of occupational power, ideological justi-

fication and legislative backing.

During the first half of the nineteenth-century, especially in the United States during the Jacksonian period of the 1830's and 1840's, it would be true to say that - "To the extent that the profession was self-conscious, the main distinctions within it were ideological - what therapeutic ideology and practice are followed provided the main line of identification and division in the profession. Medicine was sectarian, not hierarchical".(90)

Such a claim is not so true of the more hierarchically minded,status conscious, medical corporations of nineteenth-century Britain. Yet, there was still the 'sectarian' dimension to medical practice in Britain and this is brought out in the response of the regulars, homeopaths, hydropaths and mesmerists to each other.(91)

In Britain, those practitioners claiming 'professional' status....."were by no means unaware of the relationship between registration and monopolization. Nor were they unaware of the benefits, particularly in terms of the control of numbers entering the profession, which they stood to gain from registration".(92)

Indeed, to underline this: "There can, in fact, be little doubt that one dimension of the campaign for medical registration involved a quite conscious attempt of medical practitioners to restrict entry to the profession; nor can

there be much doubt that practitioners were fully aware of the likely effect of this on the level of their own incomes".[93] Indeed, this was part of William Cowper's argument[94] when he requested permission to introduce his medical bill, which after some modification, passed into law as the 1858 medical Act.

The regular practitioners in Britain and the U.S.A., created the basic conditions which would effectively develop into a virtual monopolization of supply, i.e. production of medical practitioners and services. This was grounded in three main achievements previously mentioned - the unification of the suppliers; the elimination, co-option, or marginalization of competitors by various economic, legislative and ideological tactics; and persuading the State to pass preferential legislation. The passing of preferential legislation has been the most crucial of these courses of action making the unification of suppliers and action against irregular competitors more effective than they would have been without it. Coupled with the control of the quality and quantity of practitioners passing through university medical faculties by the end of the nineteenth-century, the regular profession was in an extremely dominant position in relation to any competition from irregular practitioners within or without its social and cognitive boundaries. As Berlant says: "Typically the creation of monopoly of supply

requires some measure of preferential legal treatment at the points of both supply and production".[95]

This may have improved the quality of primary health care yet it had the unintended consequence of making provision of that care to the majority of the population, more difficult for some time.[96]

1.7. Monopolistic and Anti-Monopolistic Medical Ideology

Paradoxically the virtual monopoly of the supply and production of medical services and practitioners within the market place can sometimes be (and has been), promoted by antimonopolistic ideology originating outside the regular organized profession. For example, "the campaign for registration in Britain which culminated in the 1858 Medical Act would be greatly over-simplified if interpreted simply or merely in terms of a monopolization strategy"[97] as "the campaign for registration was not simply an attempt to erect a legal barrier between the qualified and the unqualified, but that a central dimension of the campaign involved the attempt to restructure the relationships between different segments of the profession in such a way as to destroy the monopolistic privileges of the medical corporations. Thus in an apparently contradictory manner the campaign for registration simultaneously involved both monopolistic and anti-monopolistic elements".[98]

In practice, the antimonopolistic ideology was used most fervently by the general practitioners in their campaign to undermine the traditional tripartite medical hierarchy of physicians, apothecaries and surgeons. By the 1820's, this tripartite division of labour no longer reflected the actual practice of the majority of regular practitioners, i.e. general practices then included not only medicine and surgery but midwifery and general pharmacy too. In fact, the demands made of the medical care system were being transformed under the impact of rapid industrialization, growing urban conurbations and changing patterns of disease/ illness.

The response of the Royal Colleges was to defend the traditional tripartite system and inhibit the development of general practice by the benign neglect of its educational requirements in any single course of training they provided. Those wishing to do general practice overcame this by the expedient of becoming certificated as apothecaries and surgeons. By means of their bye-laws, the Royal Colleges prevented general practitioners from any participation in their policy-making bodies. Thus, prevented from any effective say in the Royal Colleges, the general practitioners responded by forming local voluntary associations which began to voice their demands. These local associations were eventually affiliated to and co-ordinated at a national level through the British Medical Association which had

been refounded along more politically moderate lines in 1856.(99) Indeed, this response of the general practitioners was highly probable given the conditions of occupational and organizational commitment prevailing in relation to the intransigent Royal Colleges, the changing social conditions of medical practice within an industrializing society, the existence of a liberal reform movement and the educational changes needed for the legitimation of the general practitioners function.(100) It was within this context that the antimonopolistic arguments of the general practitioners were aimed at the monopolistic privileges of the Royal Colleges. These Colleges were not opposed to the principle of registration but rather to the demand for a single register which threatened their traditional privileges and status.

"Thus,the demand for a single register was, in effect, a demand for the abolition of the tripartite structure and for the dismantling of those legal restrictions which were very much a part of that structure, and which were designed to reserve a particular kind of medical work for each of the three grades of practitioner".(101)

The task of defending the traditional monopolies constituting the tripartite division of medical labour was becoming increasingly difficult as the liberalising effects of the reform movement, in its laisez-faire phase, gained ground and momentum during the first half of the nineteenth-

century.

"Given that monopolies of all kinds were increasingly coming under attack during this period, it is not surprising that on seeking to undermine the tripartite structure the general practitioners, and their parliamentary allies, should have emphasised the monopolistic character of the institutions against which their attack was directed".(102)

Yet also..... "Clearly discernible within many of the reformers' comments was the antimonopolistic sentiment of laissez-faire ideology".(103) However, it was an ideology which was quickly ignored when most general practitioners 'united' with other regular practitioners against professionally educated (and later registered) 'irregular' practitioners, notably the homeopaths.(104) This is a dimension which cuts right across the historiographical attempt to interpret the 1858 Medical Act simply as a piece of legislation to demarcate the "qualified" medical practitioners from the "unqualified" ones by means of formal registration of those defined as "qualified practitioners" in the Medical Act.

This is to say that the legislative demarcation made between qualified and unqualified medical practitioners in Britain is further complicated, and interestingly so, by the additional demarcation between 'regular' and 'irregular' practitioners on the basis of the anti-quack ideology of

those same regular practitioners. To disregard this distinction, which cuts right across the qualified/unqualified 'labels', is to simplify the situation in line with conventional medical ideology by ignoring such interesting anomolies within the 'professional' medical system. In fact, I would go so far as to say that the 'professional homeopath' was, and is, one of the occupational anomolies par excellence within the British medical establishment to date. [Another one, also having earlier historical roots, would be the organized medical hypnotists. Hypnotism being the twentieth-century descendant of mesmerism and animal magnetism].

I do not believe it is true to claim, as Waddington does, that J.L. Berlant argues for an interpretaion of the medical registration movement in nineteenth-century Britain as simply a monopolization strategy.(105) Berlant does recognise antimonopolistic elements when discussing the erosion of some of the traditional privileges of the medical corporations by laissez-faire and liberal reform arguments.(106)

However, he goes on from there to demonstrate how these traditional privileges were replaced by new ones which functioned to extend medical monopolization but which had a different legislative basis. This produced a different configuration of institutional alignments within and between the medical and political systems. The key to this new configuration of the monopolization process was the

cognitive, social and political advantages gained by licensed practitioners over unlicensed ones, which was legitimated by Parliamentary support of the 1858 Medical Act. This Act of 1858 made it illegal for anyone other than a qualified, registered and hence State-approved practitioner to occupy State medical posts. As Berlant correctly states,

"The licensed medical profession was given a new legal privilege - a monopoly on state employment".(107)

The State thus increased the

"marginal utility of a licensed practitioner's services by legally guaranteeing the quality of licences",(108) which gave the public the strong impression that State-approved practitioners were better than those who were not so approved. Within that assumption the regular medical profession made quite clear its continued ideological disapproval of all irregular practitioners, registered or not.(109) Overall, Berlant concludes that the regular medical profession adapted to the critical forces of liberalism whilst preserving, if not improving, its overall interest position in relation to the wider society.(110)

However, in the United States antimonopolistic aspects of populist Jacksonian democracy were harnessed by the 'irregular' medical practitioners and their supporters to eventually undermine the coercive aspects of local legislative

monopolies some of the regular medical societies had achieved between the end of the War of Independence and the 1830's. The irregulars were also able to prevent any further coercive legislation from being passed by State legislatures. The regular physicians saw that much of the licensing legislation was unenforceable and began to have second thoughts about helping or enforcing the laws that did exist.(111)

British reformers' ideology had monopolistic and anti-monopolistic aspects which via the 1858 Medical Act, began the formation of a unified but differentiated profession. The monopolistic strategies of American practitioners failed until the 1890's. The structuration and political contexts of each explain these differences.

Even though divided by various degrees of status and privilege, those very elements of differentiation and points of conflict within the medical profession had definite established roots in history. That is to say the medical corporations were social institutions and.....

"may be regarded as practices which are deeply sedimented in time/space".(112)

As such, the medical occupations, with their respective elite medical corporations, formed systems of social interaction. Thus they maintained certain degrees of interdependence of action. The action of any doctor occurred

within the bounded conditions of action created by the total social medical and political systems. Although in conflict, the medical estates formed an integrated system of interaction.(113) The regular medical estates were often in conflict over occupational task-boundaries, acquisition and defence of status and privileges. In the face of what was perceived as a deep social, cognitive, philosophical and therapeutic threat from the homeopaths (professional and lay), they presented a fairly united ideological front which effectively kept the homeopaths out of the crucial policy-making 'command posts' of the regular medical institutions. They were helped in this by the fact that the professional homeopaths were sufficiently committed to the model of the professional medical practitioner as a 'liberal educated gentleman' to engage only in generally defensive strategies. However, if their continued existence was directly threatened, or if they suffered definite public injustice or insult, then they would take the offensive. (The original Medical Bill of 1858 previously referred to was an example of the first kind of threat they responded to. The outcry they made when the Treatment Committee of the Board of Health suppressed publication of their hospital returns on cholera patients during the 1854-5 cholera epidemic is an example of their second kind of response).(114) However, such piecemeal but organized response (particularly when numerically outnumbered), which was ideologically and institutionally parasitical

upon the regulars for a model of medical practice and organization, was to have long term (detrimental) consequences for the professional homeopaths in particular and the homeopathic movement in general.

The point of referring to the existence of antimonopolistic elements within a specific monopolization process, along with the contingent and variable outcomes such elements and processes had in the contexts of Great Britain and the United States of America,is to show that medical ideology is a 'many splendoured thing'. That is to say, a single ideology may function in different ways given different target groups and differing political contexts. Or again, different ideologies may be employed against different 'targets' given the nature of these targets as interpreted (or misinterpreted) by the regular practitioners. These 'targets' may be internal or external to the ideological/institutional boundaries constructed by the regular practitioners or by specific medical groupings within the regulars. So, in the British medical registration reform movement an antimonopolistic laissez-faire ideology was employed in an attempt to undermine the monopolistic privileges of the medical corporations and their respective elites. However, such a laissez-faire argument was suspended when dealing with professional or lay members of the homeopathic movement/organizations in Britain. In fact, another substantive ideology was employed altogether which functioned to

unite the majority of regular practitioners against the 'heretical' homeopaths. It also engaged the regulars in a lengthy campaign of stigmatizing the homeopaths as 'quacks', 'frauds' and 'charlatans' on the basis of what were claimed to be 'rational' and/or 'scientific' grounds. These grounds were actually tacit sociocognitive criteria rooted in medical tradition and professional culture rather than in 'objective' i.e. intersubjectively testable, experimental situations that were reliably reproduceable .

1.8 Medical Knowledge, Standardization and Market Control

The process of monopolization not only operates at the level of medical organization, power, institutions and ideology, but also at the equally important level of medical knowledge - its production, organization, distribution, storage, transmission, application and alteration. Thus, we shift our angle of understanding from a consideration of the development of the medical 'profession' as an organized specialist work community to that of an organized specialist epistemic community.(115)

Nineteenth-century Britain and the United States of America experienced an increasing 'scientification' of medical theory and practice, the emergence of national education systems and the increasing functional integration of huge areas of social life under the impact of industrialization, urbanization and bureaucratization. The scientification

of medical research and practice produced greater standardization of medical knowledge. This knowledge was also produced at an increasingly greater social distance from the 'sick person', a model so central to the theory and practice of earlier heroic and neo vigorous medicine.(116)

1.8.1 Credentialing and Control

The nineteenth-century was a period marked by the 'professionalization' of many occupations as well as regular and irregular medicine. Professionalization is that process by which.....

"producers of special services sought to constitute and control a market for their expertise".(117)

The creation of these professional markets also meant the creation of a new form of social inequality. This inequality was different from the earlier form based upon aristocratic patronage. It was also different from that based upon property and equated with entrepreneurial capitalism. Its central feature was the newly emerging occupational hierarchy based upon a differential and unequal system of competences and rewards.

"the central principle of legitimacy is founded on the achievement of socially recognised expertise, or, more simply, on a system of education and credentialing".(118)

'Professionalization' was thus a widespread process whereby certain upwardly mobile occupational groupings sought to transform one kind of scarce resource, i.e. special knowledge and skills, into another kind, i.e. social and economic rewards.

"To maintain scarcity implies a tendency to monopoly: monopoly of expertise in the market, monopoly of status in a system of stratification".(119)

The early nineteenth-century hierarchical system of 'professional' status, especially within the British regular medical practitioners was basically determined by the social position of the practitioners' clientelles rather than by the knowledge and techniques that were applied. However, the physicians laid claim to being a 'learned profession' due to their university connections and hence constituted a 'cognitive elite' which serviced various 'client elites' e.g. aristocracy, gentry, wealthy urban and rural middle classes such as the industrialists and merchants. The bulk of medical care, numerically speaking, was left to the apothecaries and the growing number of apothecary-surgeons. What distinguished the regular physicians from the lower branches of medicine was their links with the universities (ecclesiastically founded and controlled, usually). Their ability to speak and write in Latin contributed to the social distancing they could accomplish in relation to the apothecaries and surgeons and hence claim a certain kind of

cognitive exclusiveness. This linked them to the 'aristocratic' oligarchies of the late eighteenth and early nineteenth centuries.

In the United States the regular medical practitioners were geographically fragmented and occupied a much more fluid, less hierarchical occupational situation. This was especially so in the rural and frontier areas to the south and west compared with the urban areas to the north and east. In this more politically liberal, socially fluid, culturally pluralistic society, restrictive monopolies were difficult for 'professionals' to establish and maintain, particularly when linked with coercive legislation. Thus.....

"To insure their livelihood the rising professionals had to unify the corresponding areas of the social division of labour around homogeneous guarantees of competence".(120)

To achieve this, the unifying principles had to be universalistic, autonomously defined by the professionals and, as far as possible, independent from traditional guarantees of status and privilege. So it was that the attempts (ultimately successful) to establish universalistic and monopolistic bases was created around "the claim to sole control of superior expertise".(121)

The creation of standardized and specialized 'professional' services included

"a tendency to monopoly by elimination of competing 'products'.....for if other standards of evaluation were allowed to prevail, the preference of the public could not easily be reclaimed from older 'consumer loyalties'"(122) i.e. alternative practitioners or practices.

Thus, in order to maintain/extend its control of the market, the medical profession had to continuously engage in the ideological task of convincing the public of its claims to competence and of the need of their own brand of medical knowledge and practice. This task became increasingly successful, on a major scale, only as the shift to the new "symbolic universe"(123) of industrial capitalism was effected during the first half of the nineteenth-century and consolidated during the second half. The major feature of this new world view was the increasing cognitive exclusiveness being created by the application of science to industrial enterprise and its effects upon the social division of labour. This new 'symbolic universe' was also, apparently, more technically successful.

Those occupations with the greatest opportunity of benefiting from and absorbing new bodies of knowledge were those with links to the universities. Thus, regular trained medical practitioners were favoured in the production of distinctive services and attaining a monopoly of competence. This institutionalisation of research and training of medical practitioners provided "the university based

professions the means to control their cognitive bases".(124)

The monopolisation and cognitive standardization of the products of trained medical practitioners is a necessary condition for market control to occur. However, the sufficient condition, for this to be widely effective, was the gaining of considerable social power and status by making their medical services more widely available. This was achieved through monopoly of state medical posts, de facto control of virtually all hospitals, and dominance of the various medico-political organizations of regular practitioners. The key to extending medical monopoly was the creation and supervision of a (state) national education system. The regular medical practitioners were then able to make fairly effective use of the production of novel medical knowledge in the universities and harness it to their monopolistic 'project' relative to the potential market made available by urbanization in Great Britain and the United States. However, in Britain it was only after university reform was achieved that the universities helped the production of scientific and technical knowledge, rather than hindered it. The nationwide reform of medical education occurred later in the United States than in Great Britain; (1910 and 1858 being the key symbolic dates relating to the Flexner Report (United States), and the Medical Act (Great Britain), respectively.

1.8.2 Cognitive Exclusivity

Only the negotiation and achievement of cognitive exclusivity in favour of the regular medical profession (relative to the polity and 'atomized' aggregate of patients) could create the necessary and sufficient conditions for the achievement of occupational autonomy, closure and relative monopoly of the medical market place.

The necessary cognitive and epistemic factors which would "facilitate control and standardization"[125] was a body of medical knowledge sufficiently esoteric and theoretical to make standardization fairly difficult. Yet it must not be so difficult as to attract few recruits, nor so easy that most people could learn medicine as a set of procedural rules. To this necessary condition, M.S. Larson (1977) adds a number of sufficient conditions. That knowledge and practices must be distinctive enough to enable the professional medical practitioners to be easily identified. They must then be formalized/codified enough to allow the product to be standardized. This entails the standardization of the producers. There must be a sufficient pace of change in the cognitive-epistemic base to prevent everyone becoming an expert[126] yet also enough change to prevent overstandardization and preserve the role of the expert.[127]

That is to say, "These considerations point in the direction of cognitive activity which is esoteric yet formalized

enough to be, in principle, accessible to all who would undergo prolonged training".(128)

The increasing conceptual-technical 'scientification' of medicine along specific lines during the second half of the nineteenth-century, reached a further point of cognitive innovation with the Bacteriological Revolution and its associated research programme, between the 1870's to the 1890's. This made the justifications for retaining Latin as the technical language of medicine redundant. A potentially far more esoteric object language was emerging from the research laboratories of the hospital wards located in the urban centres of continental Europe.

1.8.3 Cognitive Unity

Such innovation is characterized not only by 'cognitive exclusivity' in relation to other competing practitioners but also a tendency to "cognitive consensus" within the institutional and epistemic boundaries of any single community of practitioners.(129) It is because of this effect that "scientific communities can define autonomously the standards of correct practice".(130)

However, the degree of autonomy from public and political interference in the internal dynamics of a scientific research programme, is significantly less in the 'applied' and science-based professional occupations. This is because science-based professional (medical) practitioners do not

address themselves directly and continuously to the 'puzzles' and 'problems' of their more research orientated colleagues. They tend to receive a higher impact of 'problems' from ordinary, everyday-life, due to their direct contact with the consumers of their standardized knowledge and practices i.e. the patients. Still, the lay public has relatively little choice but to accept the definition and criteria of 'scientific' medical theory and practice established by the regular medical community.(131) This is accomplished relative to specific configurations of medical ontology, epistemology, methodology, techniques, tools, occupational status, organizational power and anti-quack ideology.

Maturing scientific and science-based professional communities display a

"structural tendency to paradigmatic unification, which excludes those who engage in a different set of practices and, therefore, have different standards of what is relevant, and different perceptions of what constitutes progress".(132)

Sociologically, these practices and perceptions are given embodiment in the institutions of the various disciplines and occupational interests e.g. British Medical Association, Royal Colleges, university medical departments, private medical schools.

Scientific knowledge and methodology was advantageous to the

attempts by a professional/professionalizing occupation to gain market control. It seemed to be a superior way of knowing about, and controlling the physical aspects of reality. The standardization and unification of producers and their products was more easily attained. This was so even though the 'pure' bio-medical sciences e.g.physiology, organic chemistry and evolutionary biology (after 1859) had little practical bearing upon actual medical practices of diagnoses, prognosis and therapy. The extended periods of training enabled the effects of occupational socialisation to be more fully unified and standardized. It was also a claimed point of demarcation between, and separation from, nonstandard medical practices such as homeopathy. In actual fact, this only really applied to the nonprofessional, i.e. unregistered, unlicensed and hence uncertificated homeopathic practitioners who combined homeopathy with all sorts of other fringe medical practices e.g. mystical/occult medicine, phrenology, hydropathy, 'mind-science' and so on.

In a world where science was becoming "the cardinal system of cognitive validation and legitimation"(133) and the universities, the main centres for the standardization of products and producers.....

"The cumulative change characteristic of normal science makes the passage of as many professionals through the centres for the standardized production of producers compulsory....."

both by "legislative fiat" and "because these centres monopolize new knowledge".(134)

Medical thought and practice in nineteenth-century Britain and the United States experienced several changes in its style of therapeutics as the location of the production of medical knowledge shifted farther away from the patient to the urban hospitals, universities and research laboratories. By the mid nineteenth-century the grounds for the standardization and monopolization of medical knowledge/practice had been laid.(135) A fairly continuous attack upon early nineteenth-century heroic-bedside medicine was evident in the 1830's. However, the effect of this criticism, and the shift to the Parisian Clinical-Hospital type of medicine in the innovating medical centres of Britain and the United States, was not evident in wider medical practice until a few generations later. By the 1870's and 1880's, the clinical-pathological hospital based practitioners dominated the medical scene. However, no sooner were they experienced and controlling the main channels of medical education and communication than a newly emerging bacteriological, laboratory based medicine was being constituted in German research hospitals and universities. New medical tools such as the achromatic microscope and microbiological staining techniques were soon integrated into the curriculum of modern medical education institutions; the Johns Hopkins Hospital (and University) in the United States of America provided the model

for, and symbol of, the 'modern' medical institution. "The stage was set for the incorporation of the bacteriological discoveries begun in the 1870's. The research branch of modern medicine was approaching (paradigmatic) unification by that time,even though practice lagged far behind".(136)

The experience and threat of various epidemics in Britain and the United States produced the organization of large scale public health authorities at national level. Granted these existed prior to the 1880's, but their scale and degree of involvement in the polity was what was new about them. The legitimation of one type and style of medicine by the state and civic authorities gave seemingly uncontrovertible legitimacy to 'modern scientific medicine'. Indeed it was claimed that:

"The triumph of scientific medicine marked the end of medical sectarianism".(137)

With this triumph the 'medical millenium' seemed but a few years away. All disease would be banished or at least curable by some specific 'magic bullet' of 'scientific medicine'.(138) But the bacteriological research began to run into anomalies almost as soon as it began to succeed the clinical-pathological model as a medical style of research, thought and practice. By the 1890's it was common knowledge that microscopic agents other than bacteria were also involved as causal agents in many important infectious diseases. Koch's

postulates[139] were found difficult to meet in practice in all cases. Further research led to their modification and when Koch restated them in 1884, after his work on cholera, he eliminated the universality of his third postulate i.e. the reproduction of the disease after innoculation of a culture into a healthy animal, by recognising that it was not applicable in every case, That is "that a bacterium could be accepted as the cause of an infection, even though the disease had not been artificially produced in an experimental animal".[140]

From this kind of description of the development of medical thought and practice, I believe we can perceive the seemingly paradoxical, but nonetheless historical character of even that which is claimed to be 'scientific knowledge'. It is historical in the sense that it is not arbitrary. It is also cumulative but not in the static, absolutely stable way usually presented by some historians of science. Scientific 'data' is transformed into scientific certified 'knowledge' i.e. facts, under conditions of developing criticism and thus the modification of the original research findings.[141]

1.9 Conclusion

In conclusion to this chapter, I will simply repeat that the monopolization thesis here presented, is not a monolithic, preordained, evolutionary stages concept of the development of nineteenth-century mainstream medicine in Britain and

the United States. It is a thesis contingent upon the internal organizations of the collectivity of medical practitioners (regular or otherwise), their ideological legitimations, and how these 'resonate' with the wider political and social systems of domination and legitimation. Of course, power and the resources it can bring are important, but power operates at a multitude of levels; cognitive, conceptual, political, social and symbolic. Those medical practitioners who were already established - ideologically, and institutionally - as part of an ongoing tradition of thought and practice, enter the medical market place with distinct advantages over any newcomers like the homeopaths. It is not pre-ordained that the dominant 'establishment' practitioners will prevail but it is proposed that, because they are historically, socially and politically, more deeply embedded in the everydayness of society, they are much more difficult for any alternative competitors to neutralize or eliminate than vice versa.(142)

CHAPTER TWO

THE ORIGIN AND EARLY DEVELOPMENT OF HOMEOPATHY

2.1 The Founder

The founder of homeopathy, as a system of medical theory and therapeutic practice, was Christian Samuel Frederick Hahnemann (1755-1843). He was born on the 10th. of April, in Meissen, which was in the kingdom of Saxony. He died in Paris at the age of 88 and was married twice during his life-time, first to Henrietta Küchler, in 1783, and later to Mademoiselle Melanie L'Hervilly, in 1835, five years after his first wife died.(1)

Hahnemann was the eldest of a family of ten children. His father, Gottfried Hahnemann, was a painter of Dresden china for the Meissen Pottery, which had its factory in Albrechtsberg Castle. While at school he showed particular interest in botany, mathematics and geometry. However, Frederick the IInd. of Prussia had ordered the porcelain factory to be raided for its products and craftsmen, so that a rival pottery could be set up in Berlin. Hahnemann's father considered withdrawing his son from the local school due to threatened impoverishment because of Frederick the IInd's. policy.

Although Samuel Hahnemann had a materially poor life he, at least, gained a full education - and a free one at that -

due to the kindly patronage of Magister Müller, the headmaster of the Meissen town school. This patronage was continued when Müller became Rector of 'The Princes School'.

2.1.1 University Education

At twenty years of age Samuel went to Leipzig University. Here he supplemented his allowance by giving home tuition in French and German to a wealthy Greek student. Even at Leipzig University his fees were again remitted, this time by the Professors of Medicine, due to the influence of Dr. Pörner, a Meissen physician and Councillor of Mines.

In 1777, Samuel moved to Vienna University because Leipzig did not have a hospital attached to it, where clinical experience could be gained. At Vienna University he became a student of Frecherr von Quarin, the physician-in-ordinary to the Empress Marie Theresa. Whilst there, an associate of Quarin, Baron von Bruckenthal, the Governor of Transylvania, gave Hahnemann the post of looking after his library and being his resident physician at Hermannstadt. During this period Hahnemann took the opportunity of reading widely as well as specifically studying chemistry, smelting and the Mediterranean languages (i.e. English, French, Italian, Hebrew, Spanish, Arabic, Syriac, Latin and Greek). He then passed his 'Examen rigorosum' and received his medical degree in August of 1779 at Erlanger.

2.1.2 Medical Practice, Wanderings and Translation Work (1779-1795)

He returned to Saxony in 1780, taking residence in the mining village of Hettstedt, but the following year he moved to Dessau where he worked in the Moor-Pharmacy of an apothecary called Häsler. It was here that he studied experimental chemistry very intensively. It was also at this time that he became interested in Häsler's stepdaughter, Henrietta Küchler, whom he married on the 1st. of December 1783. Later that year he moved to Dresden where he met the notable French chemist Lavoisier. Whilst at Dresden he was the locum for the medical officer of health and gained experience at the military hospital, school, orphanage, workhouse and prisons. This also helped form his 'liberal' attitude to the treatment of social misfits, especially those considered insane.

Between 1783-89 they moved several times due to Hahnemann's desire to gain fuller laboratory experience, and because his integrity regarding medical ethics reduced his income to the extent that he and his wife had to move from the large town to the smaller towns and villages. Grave doubts as to the integrity of current medical practices were forming in his mind at this time.

He and his wife moved from Leipzig in 1789 and settled in the small village of Stotteritz. Here Hahnemann survived by working as a translator of medical books. It was whilst

translating Cullen's "Materia Medica" in 1790, that he was struck by what was said regarding Peruvian Bark (later called Cinchona Bark). He began to test its effects upon himself because he disagreed with Cullen's explanation of its effects in therapy. During his experiment with the bark upon himself (what we now call field pharmacology), he took careful note of the symptoms produced, their duration, intensity, psychological effects and the environmental conditions under which the symptoms lessened or increased. He likened the symptoms produced to those of intermittent fevers. Over the following six years he studied and tested many other standard remedies.

2.1.3 The New System Developed and Explained (1796-1810)

In 1796 he published his "Essay on the New Principle" for determining the curative properties of drugs, in Hufeland's Journal. Those six years had confirmed his conviction that treatment should be by substances which, when taken in more or less substantial doses, could produce in a healthy person a symptomology as similar as possible to those characteristics of the disease or disorder to be treated. The totality of symptoms - physical and psychological - he called a drug-picture. His method of establishing what the specific symptoms of the drug-picture were was called a drug proving. The interesting innovation was that it was to be carried out upon healthy individuals.

Out of his experience during the scarlet fever epidemic in Europe, in 1799, he concluded that if a remedy was diluted its effectiveness increased - it became more potent. He found this to be the case with Belladonna, a derivative of Deadly Nightshade, which produced the symptomology of scarlet fever. He further argued that the giving of one remedy at a time - his principle of simples - was best. Thus, by about 1800, he was well on his way to affirming the three characteristic principles of homeopathic practice.

[The Law of similars: "similia similibus curantur (or curentur) variously translated as 'like is cured by like' and "let like be cured by like".(2) The first translation states a causal law, the second a methodological principle of drug test and selection ; the Law of Infinitesimals or Dilutions and hence of drug potency; the Law of Simples, or single remedies]. In relation to the heroic medical practice of his day, these principles, or therapeutic 'laws', ran counter to standard practice of certificated physicians in general. Thus, homeopathy was against 'allopathic' orthodoxy(3) in that it was anti-heroic and against polypharmacy.

In 1810 he published "The Organon of the Rational Art of Healing", which set out in detail his homeopathic principles. These principles he described as being based purely upon experience and hence only confirmable or refutable by

experience. The 'Organon', (shades of Bacon), was translated into French, Hungarian, Swedish, Russian, Italian, Spanish and English between 1824-33. By 1836 it had been published in the United States in order to provide a readily available authoritative basis for emigré homeopethic physicians. These had begun to arrive there from 1825 onwards and create medical schools through which homeopathic knowledge, practices and practitioners could be produced, reproduced and diffused.(4)

2.1.4 Homeopathy Institutionalised, Diffused and Opposed (1811-30)

The year following the publication of his 'Organon', Hahnemann returned to Leipzig in order to qualify as a professor of medicine. It is interesting to note that he did not write his examinable work on his homeopathic research, but upon the Helleborism of the Ancients.(5) After qualifying as professor he began to disseminate his new system of treatment and gathered a few disciples around him. His practice as a physician increased but his principle of dispensing his own drugs earned him the anger of the apothecaries. He dispensed his own drugs in homeopathic dilutions in order to have control over their quality. Thus, his detailed instructions upon how to prepare drugs homeopathically - as tinctures or powders - are interpretable as procedures to ensure standardization of drug product. This drug preparation had originally been in the hands of physicians but had gradually been taken up by

apothecaries and legitimated in law. So here was Hahnemann asserting an ancient position and earning the wrath of the apothecaries.

Hahnemann and his youthful disciples formed a 'Provers Union' in order to extend analysis of the total symptomalogical 'picture' of drugs. His main opponents at Leipzig during his professorship were Dr. Clarus, Professor of Clinical Medicine and Privy Councillor at the University; Dr. Robbi, Professor of Medicine; and a publisher called Baumgärtner. At one point Baumgärtner asked Dr. Robbi to write a denunciation of homeopathy. Robbi declined due to pressure of work but handed the task to a senior student and assistant, Constantine Hering. To do justice to Hahnemann's work, Hering read his published books, retested some of the provings and tried out some of his remedies upon patients. He was amazed that they worked and he became a convert.(6) The work of the Provers Union began to lead them to conclude that some medicines were more active in some persons than in others, thus bringing the aspects of physical constitution and psychological temperament into the assessment of drug potency, and hence into the construction of 'drug pictures'.

It would seem from this that Hahnemann was not only involved in what we would today term 'experimental field pharmacology' but also 'psycho-somatic medicine'. Returning, for a moment, to Hahnemann's opponents. Dr. Clarus, the

Professor of Clinical Medicine at Leipzig University, was regarded as -
"the highest medical authority in Saxony at the time", but he "exercised his power to refuse to pass students whom he considered too involved in homeopathy".(7)

Although his opposition to homeopathy was not of the virulent kind expressed by some of Clarus' colleagues, who thought that Hahnemann's lectures should be suppressed by force.(8)

Hahnemann's manner of criticising heroic medicine, however, did not generally endear him to his contemporaries. His criticism of the whole of regular heroic therapeutics was done in an aggressive manner and this probably explains some of the rejection of his alternative system of medicine. But this was standard practice when trying to clear some 'intellectual space' for a new medical system in the late eighteenth-century. Yet, although his opponents rejected many of his ideas, Hahnemann was regarded as one of the best practicing physicians of his time, and a seeker after medical truth.

His criticism was not limited to physicians but also earned the animosity of the apothecaries. He was scathing in his attacks on 'bad' apothecaries but gave the impression that he was talking about <u>all</u> apothecaries. His basis for criticism was not only the 'objective' poverty of the education, training and knowledge of the apothecary in pharmacy but

his own experience and skill in preparing his own medicines, according to his own standardized practices. He thus conflicted with the legal privilege of apothecaries to prepare medical prescriptions, a right they were not about to give up.(9)

Hahnemann's explicit anti-heroic position can be traced back to at least 1792, in his comments upon the bloodletting practices of the physician-in-ordinary to Emperor Leopold the II nd. of Austria. It was in that year that the Emperor had died under circumstances which brought grave doubt upon the validity of the treatment he had been given. Lagusius, the Emperor's physician, had tried to combat the Emperor's fever by bloodletting. The first attempt had brought no relief. It was repeated a second, third and fourth time, with no successful outcome. Hahnemann was astonished at the whole episode and wrote in the 'Anzerger' newspaper that he could see no 'scientific' justification for the drawing of blood four times when the first and second had failed. He demanded the doctors concerned to publicly justify their procedure. Lagusius promised a complete bulletin but it never materialized. Reaction to Hahnemann's challenge to the attending physicians varied, but many other physicians resented it and a long controversy began in the pages of the newspaper.(10)

The most persistent objection to homeopathy was expressed against the Principle of Infinitesimals (or Dilutions).

The regular heroic physicians and apothecaries regarded it as utterly irrational to claim that the effectiveness (or potency) of a drug increased the more it was diluted. This claim was basically seen as counter-intuitive and hence therapeutically non-rational. However, the similia principle, to which it was normally linked had an ancient pedigree. To the apothecaries the Principle of Dilutions was not just counter-intuitive, but also counter-productive in relation to their trade. If applied to their craft, their turnover of materia medica would decrease and hence affect their income and profits. It would also mean that new apothecaries would find it inexpensive to set up a business which produced homeopathic medicine. This would increase the potential number of apothecaries and affect the market, depress the price of drugs and thereby income of the apothecaries, due to the surplus of producers and reduced turnover of materials.

Thus, although there were so-called 'rational' objections to homeopathic doctrines these were not entirely unrelated to occupational anxieties aroused by the possibility of their veracity. Indeed, the Leipzig Apothecaries Guild took proceedings to stop Hahnemann dispensing his own medicines.

Apparently "a law, 'Constitutiones Frederick II Imperatoris' had recently taken a turn in their favour. It restricted the compounding of mixtures to apothecaries; other statutes

prevented the doctors from giving any medicine directly to the patients".(11)

Hahnemann refused to conform to these statutes on the grounds that the standards of preparation, even of the same remedy, varied to such an extent that to have entrusted homeopathic medicines to the regular apothecaries would have imperilled the quality of homeopathic remedies.

Encouraged by a number of Leipzig University lecturers and other physicians, the apothecaries presented a complaint to the Leipzig town council accusing Hahnemann of breaking the law. He was brought before a court on the 15th. of March 1820 and ordered to stop preparing and dispensing his medicines, otherwise he would be fired. Although ratified by the government, this decision was compromised in November of 1821, and Hahnemann was allowed to dispense under limited conditions.

Eventually, some apothecaries were willing to prepare medicines to homeopathic requirements, but the apothecary Lappe of Neu-tendorf, was the first iatro-chemist to prepare them according to Hahnemann's methods, from his own convictions.(12)

Increasing intolerance from physicians, apothecaries and lay people, eventually resulted in Hahnemann leaving Leipzig in 1821. However, he received protection and employment from Duke Ferdinand of Anhalt-Köthen. The Duke

became a patient as a consequence of the recommendation of of the governor, von Sternegg, who had been cured by homeopathy. A decree was issued which allowed him to practice homeopathy but he couldn't dispense his remedies. This was rectified, on the 2nd. of April 1821, by a personal letter from the Duke granting Hahnemann permission to dispense his own preparations on the basis that it was understood to be 'scientific research'.

Towards those who opposed, misrepresented or tried to hybridize his system with non-homeopathic ones, he was scathing. Quite understandable in the light of the attempts to suppress his medical cosmology, to conduct ad hominem campaigns against him, to abuse him and his followers by "criminal process, coroners inquests, expulsion from medical societies, deprivation of hospital appointments, exclusion from periodical literature, social and professional ostracism".(13)

However, during his time at Köthen the conflict with anti-homeopaths quietened somewhat (1821-34), but during this time his wife, Henriette, died on the 31st. of March 1830. Hahnemann was 76 years old. The following years busily involved him in fighting the epidemic of Asian Cholera which was sweeping Europe. During this epidemic he discovered what he considered to be the effective homeopathic remedy - Camphor, Veratrum album and Copper. His mortality figures were drastically lower than those using regular

treatments. This is not to draw any causal connections between treatment and therapeutic 'success' or 'failure', only to point out that on the basis of the criteria of the time, Hahnemann's 'success' was not absolutely fortuitous since later homeopathic treatment in the London cholera epidemic of 1854-5 also had comparitively low mortality figures.(14)

2.1.5 Parisian Practice

In 1834 he re-married, at the age of 80 years, this time to one Marie Melanie O'Hervilly-Gohier, who was said to have arrived at his home in Köthen "dressed as a man, and complaining of trigeminal neuralgia".(15) Within three months of meeting they were married and living in Paris. Here she helped establish him in a wealthy practice which enabled him to give treatment, free of charge, to the urban poor who came to him. For the following nine years he was widely acclaimed there.

In 1843, Hahnemann died. He shared a grave with two of Melanie's lovers, prior to her meeting him, but fifty-five years later, in 1898, his friends had his body removed to Pere La Chaise alongside the grave of his beloved Melanie. His tombstone was inscribed with the phrase 'Non vixi inutilis' - "I have not lived in vain".

2.2 Medicine at the Time : Late Eighteenth-Century

The development of medicine by the last quarter of the eighteenth-century, saw the demolishing of the phlogiston theory under the impact of the analytical chemical philosophy introduced by Antoine-Laurent Lavoisier (1743-94), especially so by the 'discovery' of oxygen and its role in respiration. Samuel Hahnemann's medical education was certainly shaped by the constraints of both the qualitative style of the Stahlian Medical Cosmology, with its animistic vitalism,[16] and the emerging quantitative style of the Lavoisian analytical iatro-chemistry. Even so, the actual practice of medicine was still very heroic, as evidenced in the systems of the Brunonian and Broussaisian schools of medicine[17] in the mid-eighteenth and early nineteenth-centuries respectively.

2.2.1 Educated and Uneducated Practitioners

The quality of eighteenth-century education was shaped more by patronage and nepotism, than by any systematic search for true medical theory and relevant medical practice. It was the 'Golden Age' of the 'successful' gentlemen-physicians and the 'successful' medical imposters. The latter aped the former in many ways, especially dress and social manners. It was the craft of surgery and disciplines of anatomy and physiology which made the greatest strides in medical knowledge and practice at this time, particularly in France,

with the formation of the Paris School of Clinical Medicine during the late eighteenth-century.[18] But such innovations were slow to diffuse to German states.

2.2.2 Medical Hierarchies

The traditional grooves of medical hierarchy continuously reproduced the requisite privileges, honours and status for the gentlemen-physicians. The same system also reproduced the necessary stigmas for the commercial-crafts of apothecaries and grocer-chemists, and the manual-craft of the (barber) surgeons. These statuses and stigmas were an ideology produced by the physicians and constantly reproduced in the talk, relationships, social traditions, customs, mores and non-verbal behaviour they displayed towards the craft occupations of apothecary and surgeon.

2.2.3 Towards a New System of Medicine

Although Hahnemann had received an accepted university medical education, even by 1781 he was becoming critical of regular medicine. His wanderings, lack of peer pressure, engagement with medical thought and practice in his translation work, and keen interest in pharmacy and experimental chemistry, certainly helped shape and direct his thinking in this critical way. (Not that others weren't critical too). As early as 1784 he spoke contemptuously of "fashionable physicians".[19] In 1786 he observed that the "most fruitful cause of death....." was "the bungling of physicians".[20]

Whilst translating Cullen's Materia Medica (Vol.1), in 1790, he disagreed with the description of the effects of Peruvian Bark and began experimenting with it upon himself. His training in experimental chemistry and applied pharmacology at the Moor Pharmacy, provided the knowledge and craft skills upon which he based his later criticisms of contemporary pharmacy. Drugs were prescribed by regular apothecaries who had little experimental knowledge of their effects and prepared them in an haphazard and unstandardized way. Polypharmacy was accepted practice. He criticised this method of mixing different medicines together in a single prescription, such that no one could predict or determine its specific action, or what the effect on the patient would be. There seemed no rational principle upon which to base treatment, or the relationships between treatment and effects on the patient. This problem he was determined to rectify. Contemporary medicine was theoretically pluralistic with physicians competing for patients (preferably rich ones). So they had to differentiate themselves from other competitors in order to claim that distinctive services and goods were being provided. This theoretical pluralism led one physician, Marcus Herz, in 1795 to say...

" 'As the healing art has no fixed principles, as nothing is demonstrated clearly in it, as there is little certain and reliable experience in it, every physician has the right to follow his own opinion. When there is no question of

real knowledge, where everyone is only guessing, one opinion is as good as another' ".[21]

However, most of the pathways of theoretical pluralism led up the mountain of heroic, interventionist practice. For Hahnemann, this situation, with each school of thought claiming to be the way of medical truth and salvation for the ills of mankind, together with his own observations of heroic pharmacy and medical practice, led him to begin to deeply question its basis. In reaction he began to grope towards a non-heroic practice based upon a natural law of cure, which could constrain therapeutic methodology in such a way that materia medica would be employed to work in line with the natural healing powers of the body, rather than bludgeon it by counter-action.

Thus, the occupational and epistemic conditions which prevailed in German 'professional' medicine[22] were the ones which Hahnemann sought to overcome on the basis of a rational, and empirical natural law of cure, which was methodologically tied to a non-heroic therapeutic practice. Yet those very same conditions actually provided the very constraints, conflicts and resistances to his thought, which finally turned it into another medical sect claiming the way of medical salvation.

Hahnemann's own provocative, belligerent and, at times, arrogant personal style, did little to prevent that happening.

His defensive-judgemental rhetoric became deeply embedded within the critical analyses which later homeopaths made of 'allopathic' medicine.

2.3 Homeopathic Principles and Practices

The development of the Homeopathic philosophy of medicine and its therapeutic implications were shaped and constrained by Hahnemann's university education, medical practice, translation work, pharmacological experience and his own personal doubts and reactions to regular medical theory and practice, from at least 1786 onwards.(23)

Indeed, whilst he was the locum health officer at Dresden, about 1773, he became increasingly dissatisfied with medicine as a science and an art. It perturbed him to the extent that he determined to give up medical practice, and he gave his reasons for doing so, publicly, as...

" 'Medicine as an art of saving life and restoring health, is, in its present state, wholly unsatisfactory; in the most skilful hands it is sterile and unable to carry out the promises of its theories; and in the hands of the great mass of its disciples it becomes a most destructive weapon. I cannot but see its want of fixed principles, the precarious character of its resources, the uncertainty of its results, and, above all, the frequently injurious effects of the violent measures resorted to as remedies. I conceive that medicine, although apparently highly scientific in its

theories, is in practice little more than empirical and routine application of remedial measures, of which we know neither the certain effects nor the laws which should determine their choice. I shall no longer remain connected with an art which both my understanding and my conscience condemn as insufficient and injurious' ".(24)

Thus it was he began earning his living by translating medical works into German, and during which time he reacted to Cullen's 'Materia Medica' and struggled towards the formulation of a natural law of medicine - but it was to take six years of experiment before he made an explicit statement in his "Essay on a New Principle" (1796) in Hufeland's Journal. It was a further ten years before he published the results of his experiments regarding the effects of medicines on the healthy body, in a work entitled 'Fragmenta de viribus medicamentorum positivis sive in corpore humano sano obviis' (2 vols. 1805). The following year (1806) he stated the basic principles of his new theory of medicine in his 'Medicine founded on Experience', which served as the basis for his 'Organon of the Rational Art of Healing' (1810). So, in fact, a period of twenty years passed between his response to Cullen's work on Materia Medica (in 1790) and his first systematic statement of the philosophical and therapeutic principles of homeopathic theory and practice in the 'Organon' in 1810.

2.3.1 Crucial Experience

The crucial turning point, in terms of the more explicit development of his reactions to accepted university medical education and practice, occurred during his translation of Vol. 1 of Cullen's "Materia Medica"[25], in 1790[26]. He disagreed with Cullen's description of the effects of Peruvian (i.e. Cinchona) Bark as a therapy for malarial fevers and the explanation of those effects. Hahnemann began to experiment upon himself with cinchona bark and noted its symptomological effects upon the healthy person. Using the standard theory that total symptomology constituted the disease, Hahnemann argued that cinchona had given him the symptoms of malaria - whilst healthy - i.e. there was no difference between the malarial symptoms of the ill person and the 'artificially' produced malarial symptoms of the healthy person. Using another standard theory, that removal of the totality of disease symptoms constituted the cure of the disease, he concluded that cinchona cures malaria in an ill person. Therefore, what causes illness in a well person will cure the same illness in an ill person.

2.3.2 Similia

On this basis he formulated his natural law of cure - '*similia similibus curantur*' - translated as 'like is cured by like'. This is the central and distinctive principle of homeopathic philosophy, and can be understood as not only a

natural law of cure (even though not necessarily a universal law), but also as a methodological principle in therapeutic practice which guides the matching of the patient's illness symptoms with the drug that produces similar symptoms in a healthy person. Thus, in homeopathy, illnesses are known by the drug which produces similar symptoms in a healthy person. The 'Similia' principle was an ancient one which Hahnemann traced to many medical practitioners, e.g. Paracelsus and his doctrine of signatures.(27) It was standard practice to trace the historical precursors of new medical theories in order to legitimate them with one's peers by showing that it was not absolutely novel (in the sense of absolutely unique and never before thought of). Hahnemann used analogies from medical history to demonstrate that the law of similars had actually been used before, but without physicians being aware of it. The therapeutic import of 'similia similibus curantur' was that a disease is cured by such medicinal agents as have the power of developing a similar disorder in a state of health. Thus, Hahnemann's historical analogies were intended to demonstrate that, on the one hand a certain substance has cured certain diseases; on the other hand the same substance has produced similar disorders.(28)

2.3.3 Provings

From the 'similia' principle, and his own experience of testing drugs upon himself, came the work of 'provings'. In order to ascertain the total symptomological effect of a drug therapy it was administered to healthy persons and they were required to record their observations of its effects (physical and psychological) upon themselves. He argued that only in this way could specific remedies be discovered for specific diseases. However, he mistakenly seemed to believe that, literally every symptom a patient experienced after the drug was taken, was due to the action of that drug alone[29] and that such action could last anywhere between ten to one hundred days[30]. The problem was, to know what to leave out. The trivia which were included in these provings was to be a durable point of contention between homeopaths and regular physicians. It was almost as contentious as the homeopathic law of dilutions, which proved to me insurmountable as far as 'rational' regular physicians were concerned.

2.3.4 Primary and Secondary Drug Symptoms

In 1796 Hahnemann found that any 'proving' of a drug produced two different and consecutive types of symptomology. For example, the primary symptoms of opium were a psychophysical elation, followed by secondary symptoms of a psychophysical depression. He concluded that the primary

symptoms were those produced by the actual effect of the drug on the organism. The secondary symptoms were the results of the reaction of the recuperative powers of the organism (i.e. vital force) in its attempt to overcome the primary effect of the drug.

"Hahnemann and his followers have held that the primary symptoms are the ones to be recorded in the provings. When the medicine is given, whose primary symptoms are identical with the symptoms of the disease, the organism's reaction to the drug (expressed in the form of secondary symptoms) will be the 'opposite' of the disease symptoms and will thus neutralize or annihilate the 'disorder of the vital force' which is the disease.

Hence, the frequently observed 'aggravation' of the disease after the administration of the indicated remedy. Since the primary symptoms of the remedy are identical with the symptoms of the disease, these latter are at first intensified; this in turn stimulates the recuperative power of the organism, (the 'secondary symptoms' of the proving) which overcomes and nullifies the primary symptoms (the disease symptoms), thus removing the disease".(31)

2.3.5 Dosage and Dilution

In seeking to ascertain the optimum level of dosage for the patient, Hahnemann experimented with dilutions of his 'proven' drugs. His decision to dilute the drugs derives from his

reaction to the heroic dosages given by regular practitioners, their iatrogenic effects, failure to cure, and unpredictability from patient to patient, even for the 'same' disease symptomology.

After establishing the law of similars and investigating the primary and secondary symptomology of various drugs, Hahnemann then considered a further question. What is the optimum homeopathic dose of any drug? His own experiments led him to conclude that large and concentrated doses were undesirable in ascertaining the effects of drugs.

"This overabundance of symptoms, as well as the severity of the symptoms, led him to believe that large doses disguised the true essence of the effects of any drug. If the dose were reduced, the superfluous symptoms would be eliminated. The more Hahnemann experimented with the proper homeopathic dose, the smaller the dose he recommended".(32)

Two intentions are discernible in the proposition by Hahnemann, that attenuated doses of drug be given and that they be prepared in a specific way (33), (a) to avoid iatrogenic side effects of heroic medicine and (b) to standardize preparation of drugs. However, the homeopaths have been divided over preference for 'low' or 'high' dilutions in their therapeutic practice. In Britain it provided the basic rationalisation of the differences between the pro-homeopathic lay movement (high dilutionists),

and the professional homeopaths (preferring 'low' dilutions but wanting to use the full range of dilutions available).[34] In the United States, during the last quarter of the nineteenth-century, similar conflict arose, often mixed with positions for and against the use of regular medical science's findings, techniques and drugs. The American low-dilutionists (i.e. 'eclectic'Homeopaths), began to criticise Hahnemann on his doctrine of the minimum dose, and the theory of the dynamization of medicine (i.e. increasing the potency of a dilution by succussion or shaking). This led to those who regarded themselves as Hahnemannian 'purists' (i.e. high-dilutionists), to defend the 'true faith' of Homeopathy by seceding from the American Institute of Homeopathy and organizing themselves, in 1880, into the International Hahnemann Association.[35]

2.3.6 Simple and Single Remedies

In reaction to the polypharmacy of his day, Hahnemann mounted a systematic pharmaco-chemical critique of regular practices. Standard prescriptions were either a therapeutic "cocktail" of remedies in a single dose, or a series of 'pure' remedies taken in rapid succession.

Advocacy of simple, single remedies by homeopaths was connected to their reaction against heroic polypharmacy but also to the fact that homeopathic provings were based upon the use of simple, single and diluted remedies upon the

healthy person. Each single, simple remedy produced a symptomology specific to it which a compound or mixture did not. The combination of drugs yielded actions found in neither of their constituent remedies when administered singly. Neither was it the case that the results obtained by a compound drug could necessarily be produced by their elements being administered singularly.

2.3.7 'Hard Core'

Homeopathy was identified by its profession of the Law of Similars. This is its 'hard core',(36) whether interpreted ontologically or methodologically. This central principle, is taken by homeopaths to be both a natural, empirically based law and a methodological rule. The rule contains a positive and negative heuristic. The positive heuristic was to extend the 'in vivo' field pharmacological experimentation to more remedies. The negative heuristic constrains homeopaths to avoid medical practices which are based upon the principle Hahnemann described as, "Contraria contrariis curantur". He described the schools of thought founded upon this principle as ALLOPATHIC because they used remedies which produced symptoms 'opposite' or counter to the ones produced by the illness.(37)

Hahnemann was a learned practitioner, deeply concerned about (a) the lack of sure, certain and rational principles upon which therapy could be administered, (b) the lack of certainty

in pharmacodynamic knowledge about the actions and effects of remedies, and (c) the suffering actually caused by the practice of accepted heroic medicine.

He was more concerned about the principles of medical practice than about the theoretical and abstract philosophical elaborations employed to justify it. So it was that "Hahnemann argued that sceptical regular physicians should not concern themselves with the logic of homeopathy, but rather look at the results. Homeopathic doses were effective in curing disease, he claimed, which was sufficient reason for their use".(38)

Philosophically, Hahnemann was a Deist, with a philosophy of biology rooted in a transcendental vitalism. In relation to his philosophical anthropology he was a dualist, understanding the human being as matter and spirit (or vital force). In the context of his philosophy of medicine, health was the maintenance of equilibrium of the vital force and the material organism.(39) Medical remedies were mediated by the vital powers of the chemistry of the body. Thus, medical remedies could affect the vital force through the vital action of the drug. Illness was the derangement of this vital force and hence the mission of the physician was to restore its equilibrium. The symptoms of the illness were indications of the attempt by the organism to restore itself to health. This interpretation of symptoms is markedly different from that of regular medicine which saw them as signs of a

derangement caused by an outside force or agency. The homeopathic physician sought to aid the attempt by the vital organism to restore itself to health. Thus, although the homeopathic physician - like his allopathic counterpart - believed in medical intervention regarding the patient's ill condition, he did so in line with (a) the vis medicatrix naturae and (b) the 'similia' natural law of cure.

Although Hahnemann theorized about the rationale as to the 'truth' of the law of similars, dynamization of dilutions (or potencies), the 'essence' of health and illness, and so on, he was more concerned about curing his patients than with explaining why they were ill and how they got better under homeopathic ministrations. In so far as

"Homeopathy arose as a reaction against barbarous eighteenth-century therapy".(40)

Hahnemann rightly fought against such a crude blunderbuss therapy whose 'core' practical principle was to make an observable impression upon the patients symptoms by using the counter-action of drugs. To the degree that the 'superiority' of regular medicine over homeopathy was not clear and self-evident homeopathy flourished.(41) Many sick people who followed a homeopathic regimen did get well. Good homeopathy was far better than bad regular medical practice. It was pointless the regular physicians and theoreticians spilling much ink in pointing out the illogicalities and inconsistencies

of homeopathic doctrine if they could not demonstrate, conclusively, the practical superiority of their own medical cosmology. Yet, on the other hand

"Allopathic errors do not establish the truth of homeopathy".(42)

2.3.8 Psoric or Miasmatic Theory of Disease

In the early nineteenth-century, homeopathy became a closed and virtually irrefutable philosophy of medical practice on the publication of Hahnemann's theory of chronic diseases in his work of 1828, "Chronic Diseases: their (peculiar) nature and (their) homeopathic cure (treatment)," (literal translation). This was not part of his original theory of 1810, and came near the end of a period of virtual isolation as physician to the Duke of Anhalt-Köthen, at Gothen, from 1821-34. This work functioned as part of a strategy of ad hoc defence against refutation or criticism of basic doctrines in his 'Organon' (1810). He differentiated chronic diseases into 'natural' and 'artificial'. The latter were the iatrogenic results of the ministrations of the allopaths. Thus,

"If any patient had previously received 'allopathic' treatment, and if subsequent homeopathic remedies then failed to cure, the reason is clear: the previous allopathic remedies had set up a serious chronic disease which was incurable. If, however, homeopathic treatment was successful... there would thus be a double triumph, once over the original condition, once over the medically induced exacerbation".(43)

Against such reasoning any criticism was futile.(44)

2.3.9 Conclusion

On the whole, in the context of the medical theories and practices of his own contemporaries and peers, his practical anti-heroic proposals seemed reasonable; his theoretical explanations were plausible and were not without historical precedent and legitimation. So why was Hahnemann and homeopathy resisted so fiercely?

2.4 Sources of Opposition to Hahnemann and Homeopathy

Besides Homeopathy's own internal theoretical weaknesses, which on the basis of the dominant medical cosmology of heroic practice and theoretical plurality, seemed like irrationalities, there were concrete, social and institutional sources of opposition. Opponents such as the physicians who felt under cognitive and occupational threat regarding their livelihood and intellectual investment in heroic practice. The apothecaries also felt their livelihood threatened by the inexpensive homeopathic remedies.

2.4.1 Physicians

"However we may regret, we cannot wonder at the desperate efforts of the supporters of Galenic medicine to discredit the new system which threatened the annihilation of all their most cherished doctrines and methods.

It must strike the unprejudiced observer as a hopeless way of suppressing a novel system of therapeutics, to abuse and calumniate its author, to persecute its adherents by criminal processes, coroners' inquests, expulsion from medical societies, deprivation of hospital appointments, exclusion from periodical literature, and social and professional ostracism. One would think that the right way would be to afford them opportunities in hospitals, to test its value, side by side with traditional methods, to court discussion in societies and periodicals, to make careful experiments with the remedies and the mode of their employment recommended by its partisans..... That the dominant majority preferred the former plan, only shows that they were doubtful of the superiority of their own methods, which, nevertheless, they constantly vaunted as the only 'regular', 'scientific' and 'rational' ones".(45)

These remarks by the homeopathic doctor, and one of the three editors of the British Journal of Homeopathy, R.E. Dudgeon M.D., say much about the relationship between homeopaths and regular physicians in the early nineteenth-century. Integral to this editorial comment is the then contemporaneous odium in which homeopathy was still held in Britain during the 1870's and 1880's.(46)

Opposition to Hahnemann began in the late eighteenth-century when, in 1784, he spoke contemptuously of 'fashionable physicians'. In 1786, he accused regular physicians of

being the most common cause of patient death. In 1790, he criticised the teaching authorities of the day, as is shown in his translation of Cullen's 'Materia Medica' (Vol.1.). Such a position was not exactly designed to endear Hahnemann to his peers. Of course, not all were against his suggestions for reform of medical practice. His first publication upon homeopathic medicine, was in 1796 in Hufeland's Journal[47] (which was a very 'open minded' journal of medicine), and was called "Essay on a New Principle" which advocated the Principle of 'Similia' as the law of cure, and argued that specific remedies for specific illness could only be discovered by homeopathic provings on healthy persons. This was immediately criticised by Dr Hecker, in the Journal der Erfindungen, who argued that the effects of medicine on the healthy body could scarcely be estimated, so their effects upon a sick person will be still more variable. The action of remedies in accordance with the similia principle was only apparent. Also, to recommend the use of poisonous substances was reckless, and something which Hahnemann could not expect approval for from the cautious physician. Hecker concluded that it led to empiricism and pernicious use of poisons.[49] Others thought the criticism Hahnemann's article attracted, had led to the "suppression of original and fruitful ideas, probably to the detriment of science".[50]

Hahnemann's further article in Hufeland's Journal in 1806, 'The Medicine of Experience', excited little response but his

'Organon' of 1810 drew further criticism from Dr. Hecker once more. In 1811 a fuller criticism appeared in the January edition of the Med. Chir. Zeitung which was so virulent that even Professor Puchett (one of Hahnemann's opponents) condemned Hecker for it, saying that "Hecker merely attacks and does not appreciate or do justice to Hahnemann's doctrine. He who wishes to judge fairly of an opinion must not hold the opposite one to be unconditionally true".(51)

It is reasonable to suggest that on the basis of pre-1810 opposition, Hahnemann's opponents intensified their criticism after this date, when he qualified as a professor of medicine at Leipzig University and began to teach his medical philosophy.(52) At this point, the Professor of Clinical Medicine, Dr. Clarus, entered the fray. Although he opposed the use of force to suppress Hahnemann's lectures - as some of his colleagues had proposed - he did refuse to pass students whom he regarded as too involved in homeopathy.(53)

By the 1820's, the critical and defensive anxieties of some regular physicians and medical lecturers had reached the point where they felt their whole world was under threat from 'the forces of darkness' they perceived at work through homeopathy.(54) Some tried to bring a sense of balance to their criticisms by pointing out both the strengths and weaknesses of homeopathy.(55)

In 1826, Hufeland had written an article to summarise the pros and cons regarding homeopathic practice, but it finally amounted to a moderate defence of some heroic practices such as blood letting and the use of powerful emetics. Successful 'cures' by homeopaths were explained (away) by reference to standard ad hoc theories of wrong diagnosis, or natural cure by the body's powers of self-healing.

2.4.2 Apothecaries

A second source of opposition was from the apothecaries, who disliked his practice of preparing and dispensing his own drugs. Not only did they respond angrily against Hahnemann but also guiltily, in that Hahnemann was quite correct in his criticism of their general ignorance of pharmacological knowledge and widely varying standards and practices over drug preparation.

The apothecaries had taken control of the dispensing of drugs by default of the physicians, and had gained legislative advantages to that effect. Hahnemann was very critical of their knowledge and practices. Since the feeling was mutual his running battle with them probably shaped the development of his later doctrine of infinitesimal doses. Although as late as 1798 he was using standard doses of camphor, by 1800 he was recommending dilute doses.(56) It was unfortunate that his criticisms of apothecaries, and other practices, were perceived as referring to <u>all</u> apothecaries, rather than

the 'bad' ones. His combative attitude did not help correct such a misunderstanding.

The homeopathic doctrines which provoked the most resistance, was that of dilutions and potency. That is to say, dilutions were not just the drug preparations to give, but the more diluted they were, the more effecive they were in producing a cure. To the reasoning of rationalistic physicians this kind of thinking was counter-intuitive. To the less educated apothecaries they were counter-productive.

In Königslutter - 1792 - Hahnemann fought against the monopoly of apothecaries to compound and dispense drugs by arguing that...
"guild privileges extended only to the compounding of medicines. The right to sell, or give, uncompounded drugs, he claimed, was not involved".(57)

His plea failed and he was prohibited from dispensing his own medicines. He met a similar situation with the Leipzig Apothecaries Guild in 1819/20 who, spurred on by the University professors, brought a successful action against Hahnemann to stop him preparing and dispensing medicines of any kind. The government modified this in 1821, allowing him to dispense medicines under limited circumstances. But by this time the intolerance against him had driven him from Leipzig to Köthen to be the physician of Duke Ferdinand of Anhalt. In time, some apothecaries did prepare drugs according to

Hahnemann's requirements. Lappe of Neu-tendorf was the first one to do so from the conviction as to the truth of homeopathic principles.(58)

2.4.3 Publishers and Public

In this context, medical journals like Hufelands were critical but open to Hahnemann and serious homeopathic articles. Other publishers like Baumgärtner were absolutely and vehemently opposed to anything homeopathic.(59)

The public was important in so far as (a) they constituted the source of the physicians livelihood and (b) some of them - the aristocrats, gentry and mercantile capitalists - could be influenced to wield political power in their favour. Most of the time it was use of the latter to secure monopoly over the medical market of the former which provided the broad parameters of the medical-politics of the regular (heroic) physicians against the homeopaths.

2.4.4 Theoretical and Practical Objections

Objections from regular university educated physicians organized themselves around certain aspects of homeopathic thought, and some of their secondary practical corollaries.

Dr. Hecker's response to Hahnemann's "Essay on a New Principle" (1796) in Hufeland's Journal, was criticism of the over-attention paid to observable gross symptomology and the assertion that a rational therapeutics had to be based

upon direct experimentation on healthy humans, since the morbific condition of ill people did not allow the display of the 'pure' effects of the medicine upon their constitution. Hecker proposed that the effect of certain remedies, in accordance with the principle of similars, was only apparent, since if it was true, smoke would not only cause inflammation of the lungs, but cure it too. He did not deny that the proving of substances upon healthy people may give valuable indications as to their suitability for employment as medicines, but he did think that the effects of medicine upon the body were so various that they could not really be estimated. The effect upon a sick person was still even more variable,rendering the notion of homeopathic specifics baseless. He concluded that his principle would lead to empiricism. The latter term being part of the anti-quack vocabulary formed by the physician elite over the whole of Europe.

These charges re-appeared in Hecker's criticism of Hahnemann's 'Organon' (1810). These were expanded a year later in the Med. Chir. Zeitung, but introduced a personal attack upon Hahnemann. He also pointed out the difficulty of actually practicing homeopathy in terms of the taking of case - histories. He did maintain his previous positive evaluation of the pharmacological experimentation on specific drug action upon the human organism.

In 1826, Hufeland gave a considered evaluation of the con-

temporary pros and cons of homeopathy as follows.[60]

Advantages	Disadvantages
1. Gives attention to individuation of cases.	1. May prevent 'rational' treatment.
2. Gives proper importance to diet.	2. Injurious to study of medicine.
3. Does away with large doses.	3. Causes sin of omission (e.g. emetics and bloodletting).
4. Simplicity of prescribing.	4. Constitutes an attack on the principles of all good medical policy.
5. More effective and reliable knowledge of the effects of drugs derived from subjects.	5. Deprives physician of respect for the healing powers of nature (N.B. but homeopaths stressed this all the time).
6. Directs attention to drug preparation and stricter supervision of apothecaries.	
7. It does no positive harm.	
8. Gives time for patients to recover.	
9. Reduces expense of treatment.	

However, most doctors were not as reasonable and fair as this. For example, Dr. Kovats wrote, in 1830, that homeopathy was...

"a system of jugglery and deception, quackery, a foolish, bungling science, an occupation suitable for idle cobblers".

That Hahnemann was...

"a wretched vagabond, a wandering ignorant barber, a blind

Paracelsist, a liar, a worthless tempter, a fool, a false, coarse, low fox...",
that Hahnemann's adherents were...
"madmen who ought to be locked up"
and that those who allowed themselves to be treated homeopethically were "fools"(61)

The homeopathic principle of Dilutions or Infinitesimal Doses was the most vulnerable part of homeopathic belief and practice. In his later years, Hahnemann even recommended that, besides administering the homeopathically proven and selected remedy with a globule of milk sugar, the very weak patient could smell it instead.

His reasons for recommending increasingly attenuated remedies are clear enough, first, his persistent reaction against heroic preparations and administration of medicines by regular pharmacists and physicians. Second, his earnest desire to avoid any iatrogenic side-effects whatsoever. Third, his experience with drug provings. All of this was allied to a predisposition to defend his position vigorously, sometimes arrogantly, whilst not really accepting any criticisms as truly valid, since they came from a 'poisoned' source - allopaths. This attitude was a mirror of the general position of regular physicians towards Hahnemann. The ideological warfare, invective and rhetoric reached such a point, that each saw the other as the repository of all that was irrational and bad in medicine.

Thus, they fixed each other into stereotypical images constructed of misinterpretations, ideological distortions and downright lies. There was also a glossing of the histories of their own, or opponent's origins, together with 'horror stories' about each others practices told as universalised Aesop's fables of medicine, to demonstrate their own position as the 'True' and the 'Good' (62)

The Miasmatic-Psoric Theory of Disease was an elaboration of Hahnemann's later years, 1821-34. This thesis was proposed in his work of 1828, but it failed to win the basic support of his followers.(63) It was later transformed into a genetic-constitutional theory of illness.

From the foregoing delineation of Hahnemann's life, thought and times in 'professional' (i.e. university educated) medical practice, it will be easier to understand the development of the relationship between regular and homeopathic physicians in nineteenth-century Britain and the United States, and their competing medical cosmologies.(64)

CHAPTER THREE

CHANGING MEDICAL COSMOLOGIES OF REGULAR PRACTITIONERS

3.1 Introduction

The various generations of 'regular' practitioners and their homeopathic counterparts, experienced the impacts of at least three broad systems of medical theory and practice during the nineteenth century. These systems overlapped and interacted with the previous ones which were also modified and eventually subsumed, at the level of 'normal' practice, under each newly emerging medical cosmology. Some aspects of the 'declining' medical cosmology were not only modified but discarded as useless, harmful or unfruitful. For example, bloodletting was virtually eliminated from medical practice by about the 1860's,(1) although it lingered on in a much restrained form up to the 1890's, even experiencing a short lived renaissence in the early twentieth century(2) but vastly circumscribed in application.

Reaction to the Heroic-Bedside medical cosmology, with its bleeding and blistering, purging and vomiting, took shape in the Clinical-Hospital cosmology with its patho-physiological and anatomical approach to morbidity, and its sceptical - even nihilistic - view of therapeutics (especially heroic therapeutics). Its students, however, were not averse to heroic practices themselves at times.(3)

Some clinicians constructed a therapeutic eclecticism which combined expectant and heroic therapies.(4)

In reaction to the expectant therapy(5) of clinical-hospital medicine a neo-vigorous therapy was constituted, partly as a response to therapeutic scepticism, and partly as a response to patient demand for physicians to actually give some medicine to them.(6) So from about the 1850's - 1890's a mixture of nihilistic, sceptical, expectant, eclectic and neo-vigorous therapies were practiced side by side.

During the 1870's research into cellular pathology began to forge ahead and in 1876, Robert Koch (1843-1910) conclusively demonstrated a causal relationship between a specific microbiological organism and a specific disease. However, clinical methodology continued to produce various therapies - expectant, neo-vigorous and eclectic - with their emphasis upon symptomatic and physiological treatment. Not until sufficient 'scientifically based', aetiological knowledge existed could a shift be made from symptomatic treatments to ones based upon known disease causation of the pathogenicity of micro-organisms. However, "Bacteriology contributed nothing to therapeutics until 1894"(7)...

with the mass production of Emil von Behring's (1856-1917) diphtheria anti-toxin.

Each shift, from Heroic to Clinical and then Bacteriological medical theory and practice, included a concomitant shift in the social locus of the production of medical knowledge from the domestic bedside, to the hospital wards and autopsy rooms, and then to the research laboratories respectively. With each of these shifts in the loci of knowledge production went an increasing depersonalisation of the sick patient; from 'person' to 'case' to 'cell complex'. In short, with each transformation of medical theory and practice instigated by emerging medical cosmologies, went a consequent alteration in the loci of the production of medical knowledge and perception of the 'sick patient'. Further alteration was produced in the role of the practitioner, sources of income, the occupational task of the medical investigator and the conceptualization of illness.(8)

Bearing this in mind, the purpose of this chapter is to outline the broad historical development of 'mainstream' medical theory and practice, and describe the characteristic of the several medical cosmologies which provided the parameters for such thought and practice. These cosmologies further provided points of critical reference and oppositional resource for practitioners of alternative and marginal medical theories and practices. For the homeopaths, this opposition to 'regular' medicine also involved the eventual transformation of Hahnemann's original transcendental, iatrochemical ,vitalistic

therapeutics into a materialistic, organicist, pharmacodynamic version under the hands of the 'professional' homeopaths who existed alongside a 'lay' homeopathic movement in both Britain and America. These lay movements claimed to keep to the "true" idealist homeopathic faith of Hahnemann,[9] yet found themselves even more marginal to the professional homeopaths and mainstream medicine during the last quarter of the nineteenth century.

The theories and practices of regular institutions of medical education in, and into which willing medical students were systematically schooled, exhibit both continuities and discontinuities between the dominant cosmologies which were diffused by and through them. Each of these medical cosmologies will be discussed and described at three levels of analysis in this and the following chapters. First, their substantive content and related constellation of practices. Second, the general historical development and institutional basis of the 'regular' and homeopathic profession's occupational system of organized autonomy and domination-subordination relationship.[10] Third, the varied functions of regular medico-political and anti-quack ideology in relation to homeopathic competition.

The historical uses of the terms 'quack' and 'quackery' have been varied, vague and (on analysis) vacuous as to whom they have supposedly been applied.[11] Such terms

are deliberately vague, emotionally loaded and explicitly used as part of a vocabulary of insult which is deployed by those who believe their own theories and practices to be 'right' and 'proper', 'true' and 'good'. Such vocabulary has been employed by dominant groups whose plausibility structures' qua 'orthodoxy' have been seriously threatened by a less powerful but significant group offering a total alternative to the prevailing orthodox cosmology. Such a threat is heightened when those challenging the orthodoxy originated from within that system and converted to the challenging alternative. The homeopaths constituted such a deep threat.

The historically constituted but not purely contingent 'fate' of homeopathy could have been otherwise, but the market system of nineteenth century medical practice was already weighed in the favour of the regulars - numerically, ideologically, educationally, institutionally and eventually legislatively (i.e. politically) - despite short term fluctuations. However, such an outcome was not predictable at the time. Hindsight, though, permits us to be able to determine the existential constraints upon this development in the context of professional medical culture and ideology constituted by received bodies of medical knowledge, their associated methods, tools, techniques and therapies, constituative configuration and systems of power and domination.

3.2 Medical Cosmologies: General Remarks

The notion of 'medical cosmology'[12] has associations with Kuhn's 'paradigms', Lakatos' 'scientific research programmes', Laudan's 'research traditions' and Ravetz's 'folk-science'.[13]

As N.D. Jewson has stated...

"Medical cosmologies are basically metaphysical attempts to circumscribe and define systematically the essential nature of the universe of medical discourse as a whole. They are conceptual structures which constitute the frame-of-reference within which all questions are posed and all answers are offered...cosmologies are not only ways of seeing, but also ways of not seeing... They exclude in the same moment as they include.

Cosmologies should not however be conceptualized as static normative frameworks - rather they are ongoing sets of possibilities, not so much states of knowledge (and ignorance) as ways of knowing (and ignoring)".[14]

I would want to comment that medical cosmologies are both states of knowledge and processes of knowing; states of ignorance and processes of ignoring - at one and the same time. Further, they are states of belief and processes of believing.

Medical cosmologies not only operate at this very general level of ontology and epistemology but also at the practical level of discourse and social interaction.

As Jewson says, they function...

"as modes of social interaction within the structures of relationships which surround the production of medical knowledge... It is contended that medical cosmologies generate, reflect and project conceptions of order and identity in the network of relationships which constitute the process of innovation in medical knowledge. They function as a medium within and through which perceptions of self and others are expressed, legitimized and institutionalized. In short, medical cosmologies are not only statements about the world but are also ways of relating to others in the world".(15)

Linking the sociological and metaphysical aspects of cosmologies, it can further be stated that, in terms of the actual agents' believing in and operating within and through a specific cosmology, the need for "ontological security"(16) can be adequately met. Therefore, one function of such a 'security system' (for the believer) is to provide a secularized, medical equivalent of a theodicy. This has to explain, minimally, the existence of, and possible resolution of, the anomic phenomena of suffering, pain and death. It has to adequately deal with those aspects of existence which may produce the disordering of the ordered, meaningful nomos (i.e. socially constituted, meaningful order of 'reality').(17)

In the medical discourse of practitioners to each other,

to patients and to the public through "domestic health" educational literature, the theodicic elements of the (medical) cosmology are communicated. Such a theodicy contextualises the specific therapies employed in treatment into a specific meaning system which legitimates the everydayness of practices in relation to health and illness. In other words, medical cosmologies organize systems of discourse and the meanings of 'health' and 'illness' for the patient. For the practitioner, the same systems are orientated in terms of actual practice (i.e. techniques, tools, methods and therapies) and the selection, organizing and interpretation of the symptoms and signs of illness, their diagnosis, prognosis and treatment. They also organize the interaction of practitioner and patient in terms of degrees of autonomy and dependency in their social interaction.(18)

Medical cosmologies are not normally set out as a list of doctrinal articles of faith which the practitioner has to 'confess' to as a sign of orthodoxy. However, in terms of the end result of the education and training of 'professional' practitioners there is little difference. In both cases the cosmology provides basic ontology, methodology, epistemology and parameters of discourse required in order to be identified as a practitioner of a particular occupational and cognitive universe. In short, medical cosmologies tend to be <u>processes of</u>

believing rather than statements of belief. Those groups of practitioners who required explicit, volitional (sometimes public) acts of belief and cognitive commitment were - sociologically speaking - 'sects' and 'cults'.(19) If the practitioner of a medical sect, or cult, 'converted' over to the regular 'orthodoxy' (whether he was originally a member of the orthodoxy or not), it was sometimes required that a public confession and renouncing of their 'sin' be forthcoming.(20) That is to say, a ritual, public, purification had to be engaged in before the 'sinner' was deemed 'pure' enough to join (or re-join) the 'angelic hosts' of medical orthodoxy.

Such cosmologies are constantly reproduced and transmitted through craft-apprenticeships, lecture, clinical examination, research, text-book, professional occupational culture and peer relationships. Their substantive content is received relatively uncritically, and not a little is tacit rather than explicit in form because of how the knowledge was acquired.(21)

The disruption of the routine knowledge and practice of any medical cosmology can occur under various conditions, but one of the most common is the frequent hiatus experienced between text-book theory and occupational practice in the face of the exigencies of the actual problem of health and illness exhibited by real patients. The responses to this basic problem are varied, ranging

from 'dropping out' prior to completing the course, or, sometime after starting a practice, 'converting' to an alternative but 'heretical' medical system. Others may have internalised the anomalies as part of the 'normal' paradoxical nature of medicine, and either continued practicing or resolved some of the moral stress caused by such paradoxical anomaly by 'advancing' their careers into medical education (with some research aspects).(22) Or, the anomalies and paradoxes may be suppressed and hence ignored in order to preserve one's internal security and the integrity of one's cognitive identity. Such are some of the strategies for maintaining or re-establishing cognitive and emotional security under conditions of personal and/or collective critical situations.(23)

Of interest to us here is the phenomenon of 'conversion' (as process and event) from medical 'orthodoxy' to medical 'heresy'. Some work, of a theoretical nature, has been offered upon this aspect of the re-direction of commitment and cognitive re-formation, entailing the transformation of discourse. Some have tried, unsuccessfully I think, to synthesize Thomas Kuhn's notion of 'gestalt switches' and 'paradigm shifts' with Peter L. Berger's ideas about the 'alternations of identity' to explain biographical alterations and disruptions.(24) Others have tried to supply an epistemological or social psychological basis for the cognitive and affective alterations which accompany shifts of commitment from one paradigm to another.(25)

These studies tend to operate at a fairly theoretical level of analysis and it becomes difficult to actually convert their findings into empirically operational descriptive concepts. Alternatively, the study by Snow and Machalek does offer a framework for empirical identification of actual converts by locating certain properties of the convert as a social type in the discourse and reasonings they engage in.(26)

However, all these studies omit to mention a basic aspect of 'conversion', 'alternation', 'paradigm shift', or 'gestalt switch' - the cost and non-arbitrary nature of this experience to the person undergoing it. Especially if it is a conversion to an heretical/deviant cosmology. It is tacitly assumed that such, subjectively experienced, phenomena are easy to accomplish and arbitrary in character - like changing one's socks,or attire - more a matter of ephemeral taste rather than existential agonizing and turmoil. Of course, the cost will vary and the arbitrariness increase the less radical the conversion in its cognitive pervasiveness and affective depth. However, to repeat, radical conversion (not mere role change) is not an arbitrary, easy or simple process (or act), it is constrained in various ways. It is also costly on many social and personal levels, whether it is a 'Damascus Road', almost instantaneous conversion, or one which takes many years through gradual and cumulative changes in

beliefs and commitments.

Whether conversion /alternation is rapid or gradual it always requires the convert to explain to others and affirm to themselves, the meaning of their past life in the light of new convictions. In short, the past has to be re-interpreted - even reconstructed - in the light of the present. This is the primary function of autobiographical 'conversion' literature, especially if the direction of conversion is from medical 'orthodoxy' to medical 'deviancy'. It also functions to confirm and consolidate the new deviant identity.(27) For the reader it functions as apologetics (to explain the 'faith' to the 'unbeliever'), evangelistic tract (to proclaim the 'faith') and as pastoralia (to alleviate the anxieties of those suffering post-conversion doubts). However, the details of this phenomena in the context of competing medical cosmologies will be dealt with in a later chapter. (cf. Ch.6) The above are only comments which indicate the kind of things which should be borne in mind in the following typological description of the developing socio-cognitive shifts in the thought and practice of regular practitioners.

However, before I continue, two cautions are in order... Firstly that,

"Any historical period contains within itself many processes and themes, not necessarily all knit together in a seamless web; there are always loose ends".(28)

Secondly, the kind of connection to be discovered employing my particular eclectic interpretive and methodological 'machinery' cannot be decided 'a priori'. It is discovered in the ongoing interaction between 'the problem', the empirical information of relevant historical documents and various problem-solving 'machineries'. This kind of approach is in contrast to recent programmatic attempts to employ 'a priori' causal interpretations[29] prior to investigation of the actual evidence. A more agnostic methodological position regarding the kind of relationship to impute to the evidence, which also adequately interprets it, is sought here. One that is more problem centred and sits loosely to epistemological and methodological systems is advocated. This tends to relocate epistemology and methodology as tools and servants, rather than intellectual masters. It also allows a certain imaginative flexibility regarding the sociological perspectives used in analysis of primary sources (which are also interpretations) and synthesis of secondary sources.

With these things in mind I will now proceed to describe, in some detail, the regular medical cosmologies which superseded each other on the basis of the shifts in the locus of the production of medical knowledge and the legitimation of medical practice. These were Heroic-Bedside, Clinical-Hospital and Bacteriological-Laboratory Medical

Cosmologies, (see diagrams 1,2 and 3 in Appendix 1, for summary of this information as to their salient characteristics, loci of knowledge production and systems of occupational control from the late eighteenth to the late nineteenth centuries).

However, it should be borne in mind that the purpose of the periodization of the various medical cosmologies is not the erection of rigid, impermeable, absolutely defined conceptual boxes regarding the historical data. The periodization is merely a judgement regarding, and an indication of, what seems to be those periods of time in which a particular system of medical theory and practice was relatively dominant in relation to other theories and practices of medicine. Each system and style of medicine existed in part or whole before each reached a definite occupational dominance. In fact it had to, as the younger generation were being educated into the new medical cosmology prior to practicing it and coming into conflict and debate with those committed to the previous system. Precursors of such systems of thought and practice can be found to exist well before the period of dominance. For example, the exemplary research of Morgagni into morbid anatomy during his professorship at Padua from 1715-71, became the intellectual and practical basis for the clinical research programme of the Paris School of Medicine from the last decade of the eighteenth century

to the mid-nineteenth century.

Periodization is an organizing device designed to keep certain aspects of an argument within temporal limitations, but that does not make it the product of arbitrary and non-rational decisions.

3.3 Heroic-Bedside Medicine (1770-1840)

The term 'Heroic Medicine' is the standard historiographical designation given a specific type of medical thought and practice. It has been investigated by a variety of medical historians[30] and its style, as expressed in the specific practice of bloodletting, has received some detailed study.[31]

Under this regimen it was the patient who had to be physically and emotionally heroic to submit to the practices of bleeding and purging. To the patient and practitioner of the time such 'heroic' methods were completely to be expected. After all, the Heroic cosmology informed the physician what to do and the patient what to expect. Until the advent of efficient, controllable anaesthesia in 1846/47, heroism was particularly required of the surgeon and his patient.

The intellectual roots of this medical system lie in the ancient Greek medical philosophies of Humouralism and Solidism.[32] Between the late eighteenth and early nine-

teenth centuries medical belief and practice was pluralistic, at the theoretical level. There were many schools of thought which competed for patients. Each school's supporters proposed their own theories of disease causation and relevant therapies. However, at the level of practice was a range of heroic practices constituted by mixes of dogmatic principles, rules-of-thumb and ad hoc exceptions-to-the-rule. It seems that the mountain peaks of pluralistic medical theory each descended to the unifying plain of heroic therapeutic practice.

3.3.1 The Theory and Practice of Heroic-Bedside Medicine

The term heroic describes a type of active, interventionist therapy practiced for much of the history of medicine but achieving occupational autonomy and dominance in the late eighteenth to (about) the mid-nineteenth century in Britain, the United States of America and Continental Europe. '1850' is a date to indicate the approximate period when it had reached a rapidly declining influence upon 'professional' practice. Remnants of the heroic approach could be found as late as 1878[33] and beyond.

Its theoretical roots were in a humoral, often monocausal, pathology of disease causation which produced the anti-phlogistic therapeutic practices of depletion, sedation and stimulation. The immediate origins of this style of medicine were located in the seventeenth century iatro-

chemical school of Georg Ernst Stahl (1660-1734) which was diffused in Britain by the chemists, Joseph Black (1720-90), Henry Cavendish (1731-1810) and Joseph Priestley (1737-1804) in modified forms and then to the New World through emigré physicians.

The anti-phlogistic practices of this system of medicine were venesection or phlebotomy (i.e. bleeding), leeching,[34] cupping, and blistering. Humoral based practices included the use of harsh diuretics, purgatives (or cathartics) and emetics. Solidist practices included tonics (or stimulants), irritants and sedatives (or hypnotics). These therapies were all used to produce a perceivable impact upon the patients total symptomology. In practice this tended to be reduced to two basic forms...
"either depletion through bloodletting or stimulation through medication".[35]

It was William Cullen (1712-90) of Edinburgh who gave heroic medicine its decisive shape in Britain and the United States. His teachings were diffused, and carried to extremes, by two disciples of his - John Brown (1735-1788) in Britain and Benjamin Rush (1745-1813) in the United States. Brown incorporated a theory of irritability he took to extreme lengths. Rush modified Brown's approach and Cullen's solidism. This did not, however, prevent him from practising massive bloodletting and administration of purgatives - especially calomel and jalap - whose laxative

actions were cyclonic in their effects upon patients. These practices and materia medica were characteristic of Heroic therapeutics and seem to have reached a peak between the 1790's and 1830's as to their being the routine practices of 'regular' physicians. They suffered general decline between the 1840's to 1860's.(36)

3.3.2 Bloodletting:Exemplar Therapy of Heroic Medicine

The rise of bloodletting as a virtual therapeutic panacea amongst regular practitioners, has been attributed to a combination of factors, including the decline of the 'doctrine of debility', the change in the type of disease epidemics, the weakness of the opposition to the 'Blood-letting Revolution' and, in England, the demobilisation of poorly trained military surgeons after the war with France.(37)

Some physicians at the time even presented statistical evidence that...
"the more one used the lancet, the better the results".(38)

Those who advocated copious bloodletting as a general practice also tended to be rather loose in their application of clinical terms and definitions.
"This led to clinical relativism rather than pathological specificity".(39)

Since the underlying practical assumption of Heroic-Bedside medicine was that...

"the pathological state of the organism could be understood by reliance on external symptoms exclusively".(40)

and...

"that anything which produced desired changes in the gross pathological symptoms of the patient was acting on the disease and was therefore a useful therapy".(41)

Physicians of the dominant heroic practice differed only as to the quantity of blood to be drawn and the frequency of the therapy upon any one patient with a specific set of disease symptoms.(42)

It was advocated as a general, desirable therapy for several reasons. First, it was demonstrable and consistent in its effects. Second, the patient was under no illusions that the physician was doing something. Third, it was applicable to a whole range of fevers (e.g. malaria, typhoid, pneumonia) which were commonly encountered. Lastly, it was "a genteel and elegant therapy, well suited to all social classes".(43)

The reasons for its widespread use then were its practical value and its conformity with medical theory. Yet its actual establishment as a major therapy, was because it worked often enough to convince its practitioners of its utility and its effectiveness.(44) The rationale for its use may have varied from physician to physician but the existential conditions for its use (i.e. fevers and inflammation) remained quite constant for the first half

of the century, until challenged by the pathophysiological knowledge of the newly emerging medical cosmology, Clinical-Hospital Medicine, from the 1830's onwards in Britain and the United States. However, this latter medical system only really became dominant in thought and practice by the 1860's onwards, by which time bloodletting was largely abandoned as a standard and general remedial agent. The conviction that...

"disease could be bludgeoned out of the patient"(45)

was gradually replaced by a more conservatory therapeutics which emphasised the building up of the patient's strength through sensible diet, fresh air, light, quiet and rest. The emerging conservative therapeutics was highly critical of previous heroic practices, especially venesection.(46)

3.3.3 Heroic Drug Therapies

(i) Calomel

Early nineteenth century regular practitioners used medicines to evacuate the stomach and bowels. To this end, remedies which could make a symptomatically demonstrative impression were sought. There were emetics to produce vomiting and purgatives (or cathartics) to produce powerful laxative action.(47)

Calomel was a cathartic, popularized in the United States by Benjamin Rush in the late eighteenth century whilst attending upon patients of a yellow fever epidemic in 1793.

Calomel is a chloride of mercury which produces irritation and purging of the stomach and bowels upon breaking down into its poisonous components. "Like bloodletting, it became a panacea for all ills".(48) Like bloodletting, it had its dangerous 'side-effects' to health. Because some of it could remain in the body, most of its side-effects were due to cumulative poisoning. In fact, deposits of mercury in the bones of some patients was, for some time, taken to be a 'normal' condition in some parts of the United States of America.(49) Indeed, quite an intense conflict was created in 1863 by the attempt of William A. Hammond, Surgeon General of the United States Army, to remove calomel and tartar emetic from the army supply table.(50)

This incident is interesting to us in that the vehemence of regular physicians, especially as expressed through the American Medical Association (A.M.A.), was partly derived from the fact of the normal conservative reaction to changes of practice and partly because "it played directly into the hands of the irregular practitioners. The Eclectics, Homeopaths and other sects were overjoyed. Regular doctors regarded this reaction as a marked threat to the prestige and position of the profession. What enraged the regular physicians most was that the ammunition for this new challenge had been given to the enemy by a member of the regular ranks, a man in the

highest medical office of the federal service".[51]

In some situations other emetics and purgatives were used. Some were poisonous minerals, others were powerful botanical remedies. They included, tartar emetic (i.e. tartrate of antimony), nitre or saltpetre and jalap. The latter was often mixed with calomel to make it palatable. Common to all these drugs was the fact that they "all produced consistent and demonstrable changes in the patient's condition".[52] They all had a debilitating and dehydrating effect on the patient's system.

(ii) Tonics, Irritants and Others

Once the system was evacuated by purgatives and emetics, tonics could be applied to improve digestion and appetite. Arsenic was one popular tonic, notwithstanding its toxic side-effects.

Quinine and Cinchona bark were especially used in the palliation of malarial symptoms. Opium was also used but its side-effects were similar to cinchona (i.e. it depressed the cardio-vascular system, irritated the gastro-intestinal organs and caused giddiness). In large doses it could cause deafness and blindness.[53]

Based upon a humoral pathology, skin irritation (e.g. blistering) was popular since it was believed to be a beneficial emission of morbific matter. Such irritation

often produced gangrene or ulcers.

"Physicians seldom gave any thought to pharmacology in their use of drugs".[54] Prescriptions, as Hahnemann and other anti-heroic practitioners pointed out, were compounded in an unstandarized way and mixed with other drugs in an irrational way. Thus, the charges of mega-dosing and polypharmacy were true but it was standard practice by regular practitioners and apothecaries. The difficulty was that when regular therapies were employed and a patient was 'cured' or recovered (or at least did not die) it was the regular therapy which received the praise; but when a patient died after the administration of regular therapies, it was in no way interpreted as the cause of the death. This we know is an illogical view of causality - even though it is a 'natural' conclusion to make. However, it was for like reasoning that elite, regular practitioners criticised homeopathic practitioners. This indicates that the normal evaluative criteria are suspended when a group is perceived (ideologically) a priori as heretical and irrational.[55]

3.3.4 Decline of Heroic Medicine, Especially Bloodletting

The historiographic consensus seems to be that heroic therapies, particularly bleeding, reached a peak between 1800 and about 1830. From about the 1830's to 1860's it suffered a serious decline, with vestiges of a very limited and circumscribed practice persisting to the end of the

century, with something of a 'renaissance' between 1910 and 1950. However, the latter resurgence was limited to a few specific illnesses. An attempt to re-evaluate it as a general therapy, on the basis of a "discarded humoral model(s) of disease"[56] failed in 1926. Even this 'renaissance' had its roots in the 1890's in Germany and the popular writing of Dr. August Dyes (1807-95).[57]

It wasn't so much that bloodletting was no longer taught or written about in medical textbooks as a general therapeutic measure (at least in theory), but that its specific use in specific illnesses was no longer recommended. This limited applicability was in direct relation to the increasing importance of clinical pathophysiological medicine throughout the second half of the nineteenth century. In short,
"Bloodletting was being given up in practice but was often retained in theory".[58]

The work of Marshall Hall (1790-1857) in England[59] and Pierre Charles Alexandre Louis (1787-1872) in France[60] contributed much to the substantive clinical criticism of bloodletting upon the basis of pathophysiological studies. However, it has been argued by Leon S. Bryan Jr. (1964) that "Neither Hall nor Louis censured the lancet. That they sought instead to make its use more judicious was an attitude fundamental to the (American) profession's approach to bloodletting in the 1840's and 1850's".[61]

Bryan further argues that few textbooks between 1830-70 actually excluded bloodletting from their therapeutics. However, there was a gradual, often imperceptible, decline of bloodletting being advocated for specific diseases during the 1840's and 1850's. During the 1860's and 1870's, regular physicians began to express the fact that venesection was widely abandoned.(62) Although it had its occasional enthusiasts.(63)

How is this decline to be explained? The answer to this has two levels of analysis. First, those given at the time this question was considered. Second, that provided by greater historical distance and the critical tools of historiography and social analysis. The Philadelphia County Medical Society discussed this issue in 1860 and gave the following reasons as to why bloodletting had declined:

1. "Change in type of diseases, and in the constitution of patients...
2. Propaganda activities of Thomsonians, Homeopaths etc...
3. Decline of bloodletting on irrational grounds...
4. Decline of bloodletting on empirical grounds...
   (a) Realization through experience that heroic bloodletting was harmful...
   (b) Empirical substitution of other remedies for bloodletting...
5. Influence of Louis' 'Numerical Method'...
6. Greater scientific knowledge...

7. Influence of certain authorities..."[64]

To which Berman (1954) adds, the impact of "therapeutic scepticism and reliance on the curative powers of nature"..[65]

We may add to these factors the influence of the gradual shift of the locus of the production of medical knowledge from the bedside to the hospital autopsy rooms and the pathology and physiology laboratories. There was also the steady reorientation of occupational control away from the patronage of the patient to the collegiate control of medical peers. This was given a legislative format with the Medical Act of 1858 requiring that all duly certificated practitioners (physicians, apothecaries and surgeons) be registered and licenced. This located the power for the evaluation of competency with the practitioners, minimizing the power of the patient to adjudicate in such matters, or control to some extent the meaning of morbidity and medical practice.

There seems to have been no abrupt abandonment of bloodletting between 1830-92 as far as a study of some American medical textbooks goes. But by 1880-92 the majority of tests did not regard bloodletting as relevant in the majority of cases in which it had previously been applied.[66] However, it was recommended in some specific illnesses. William Osler (1849-1919) for example, advocated it in pneumonia cases as late as 1892.[67] This very limited

application was maintained even during a resurgence of the practice during the first three decades of the twentieth century[68] which shows that "bloodletting in the twentieth century reveals the stability and essential conservatism of therapeutic medical practices regardless of their intellectual underpinnings".[69]

In other words, the "empirical efficacy" of bloodletting "could easily survive the demise of humoralism and be fitted into modern cardiovascular schemes. Unquestionably, however, such a shift robbed bloodletting of its systemic anti-inflammatory indication and panacea status".[70]

Although the decline in the practice but not necessarily the theoretical legitimation and advocacy of bloodletting was fairly gradual between the 1830's and 1860's, it still created intense conflict between the physicians trained in the lancet and other heroic practices and those emerging from the new centres of medical excellence and innovation, in France and Germany, trained in the theory and practices of Clinical-Hospital Medicine. This was a system of medicine founded upon the bio-medical disciplines of anatomy, morbid anatomy, physiology and pathology coupled with a new range of medical techniques and tools such as statistics, auscultation, the stethoscope and microscope. One such conflict erupted during the 1850's in Edinburgh and exemplified the sometimes painful events created by the clash of different medical cosmologies with their different

interpretations and emphases regarding the "disease entity", the sources of authority regarding medical theory and medical therapy, and the relevance of scientific knowledge for that same theory and therapy. This conflict will be examined next, but suffice it to say at this point that we have a reasonable idea of the basic substantive theory and practice of heroic bedside medicine.

3.4 Cosmologies in Conflict : the Alison-Bennett Controversy

Given that competing and/or conflicting medical cosmologies do not exhibit total, absolute incommensurability[71] - since they all deal with 'the same' existentialities of 'health', 'sickness', 'suffering', 'pain' and 'death' - the issues between William Pultney Alison (1790-1859) and John Hughes Bennett (1812-75) resolve into problems of medical interpretation, especially regarding the phenomenon of 'inflammation'. Such differences were constituted by the different views of the sources of authoritative knowledge permitted to shape medical theory and practice. This is not to fall into the relativistic 'dead end' of arguing that the different interpretations causally produced different physical perceptions and images upon the visual/sensory equipment of the different observers. It is to argue though, that the different cognitive-interpretive equipment allocated different weightings, meanings and understandings to such perceptions.[72]

This distinction between perception and interpretation is merely analytic, such a distinction does not occur in the actual existential act of 'seeing'.

The controversy largely took place within the environment of Edinburgh University and the pages of the Edinburgh Medical Journal. Alison was a clinician and undoubted leader of the Scottish medical profession. Professor of the Practice of Physic since 1843 and related to John and James Gregory, he was "the intellectual descendant of William Cullen".(73)

Bennett, his implacable opponent, was a graduate of Edinburgh (1837) but had spent the following four years studying medicine in Paris and Berlin, where the patho-physiological style of clinical medicine was flourishing. In 1841 he took up his appointment as professor of the institutes of medicine. He immediately began to teach the Clinical-Hospital medicine, with emphasis upon pathology, microscopy and clinical analysis.

The tradition in which Alison had trained, practiced and taught was orientated to the diagnosis of patient symptom-ology as specific clinical phenomena with definite natural histories. The 'clinical entity' was defined by its symptomology and its process of development over time. The source of the production and legitimation of medical theory, as well as the source of therapeutic innovation,

was the patient's bedside.[74]

In contrast, Bennett

"looked to the physiology and pathology laboratory as one locus of authority for both constructing and testing therapeutic theory and the practice it defined..... Theory informed by pathophysiological knowledge acquired in the laboratory could explain and even guide action at the bedside, Bennett believed, while prior theory could be affirmed or invalidated by criteria generated by laboratory research. Similarly, advances in scientific knowledge about disease could generate therapeutic change and progress".[75]

On this basis the knowledge produced could be better standardized. It wasn't that Bennett considered medical knowledge acquired at the bedside was to be discounted in the formation of medical theory and practice, only that its scientific validity required rigorous experimental testing in the pathology and physiology laboratories. In short, he did not regard such knowledge as the paramount authority in the construction of medical theory or the determination of medical practice.

The Alison-Bennett controversy was symptomatic of the struggle at philosophical, methodological, intellectual and practical levels of the differences between cosmologies of Heroic-Bedside Medicine and Clinical-Hospital

Medicine. Sociologically, the struggle over the presuppositions and shape of medical theory and practice were rooted in the processes of the replacement of the older generation of practitioner elites by the younger and differently educated new generation of practitioners. Institutional displacement of the older centres of medical excellence, like Edinburgh, with newer ones in France and Germany, also had its 'knock-on' effects in the status hierarchy of medical, educational institutions.(76)

As the new generation of medical students were attracted to the centres of medical excellence and innovation, they were socialized into a particualr way of thinking and doing. The attitudes, cognitions, intellectual framework(s) and substantive knowledge was diffused through the disciples to fellow practitioners as they took up career opportunities in hospitals, general practice, universities, consultancy and research posts. In time the older generation and its ideas suffered due to biological attrition (death), intellectual criticism, epistemic and innovative exhaustion. They did accomplish some successful ad hoc adaptations and defensive manoeuvres for a time but eventually, outnumbered, outmanoeuvred and out-argued the command posts of the medical institutions eventually became occupied by those of the new approach to medical theory and practice, and so began to shape it to their image of what constituted proper, scientific medicine - just as the previous generations had done before them. Yet, both continuities and discontinuities

continued to exist between these different medical cosmologies. For example, although the locus of the production of medical knowledge moved from the bedside to the hospital dissection and physiology rooms, the actual therapeutic tools available changed little, especially in terms of the materia medica and actual drugs employed.

By the 1850's the practice of bloodletting was nearly defunct but it still received theoretical support as a general therapy. Indeed, it had to be defended at the theoretical level, even though its practice was less and less frequent. If it was not defended it would have been tantamount to admitting the non-validity of all past therapeutic claims for bloodletting. The change-of-type theory was central in this continued legitimation of bloodletting at the theoretical level, whilst still providing a rationale as to why the incidence of its use had so drastically declined.(77) The theory claimed that either the nature of disease had changed from a sthenic to an asthenic condition (i.e. from symptoms characterized by a hard fast pulse, overexcitement, high temperature and delirium, to one characterized by a weakened constitution, slow gradual pulse and low temperature), or the constitution of patients had radically altered.

In the earlier part of the century there had been a typhus epidemic (1800-03) followed by a period of relative calm (1803-17) in the United Kingdom. However, in 1817-21 an

epidemic of relapsing (or famine) fever struck which, unlike the enfeebled condition of the typhus patients previously, was of a sthenic character. Bloodletting proved very successful in making an observable impression upon the symptoms.(78)

However, in 1831-33 a typhus epidemic again broke out. Bloodletting was tried but proved unsuccessful and supportive, or stimulative therapies, like alcohol, were used. These changes in the seeming character of the disease directly affected therapeutic practice. The practice of bloodletting declined but its legitimating theory remained. The justification for this decline being legitimated by the change-of-type theory, which had two forms. First, that the nature of disease had radically changed (from sthenic to asthenic) and second, that the constitution of the patients had changed due to urban living.(79) This change-of-type theory was also used, by Alison, to explain the apparent success of homeopathic treatment of pneumonia, in that it was a non-heroic (i.e. non-bleeding) practice which he thought was based upon the healing powers of the body itself. Thus,

"Both versions of the change-of-type theory... explained the decline of bloodletting in practice while preserving the theoretical value of bleeding... This resolved the apparent paradox between theory and practice while supporting the correctness of both current and prior therapies".(80)

The theoretical rejection of bloodletting was impeded for intellectual and social reasons. Firstly, Heroic-Bedside medical theory remained substantially unchallenged as a totality of thought due to the absence of...
"a competing theoretic schema capable of drawing the existing paradigm into question".(81)

Secondly, few physicians of the Heroic-Bedside school were willing to publicly admit that they - indeed several generations of regular practitioners - had been practicing theoretically invalid and therapeutically dangerous medicine. Indeed, the leaders of the 1850's profession had been largely trained in the 1830's when bleeding was still standard practice.

Thirdly, the possible rejection of the theoretical underpinning of bloodletting could constitute a threat to the status and authority of the regular practitioners, in the eyes of the public.

These factors constrained regular practitioners of Heroic-Bedside Medicine to have to explain the hiatus between theory and practice; the change-of-type theory being a rationalization generated by status anxieties and intellectual anomaly. It was an ad hoc defensive strategy, (although it had some experiential evidence to sustain its advocacy) which was...
"embraced less for the intrinsic merit of its evidential

foundation than for the way the theory satisfied certain social and intellectual needs".(82)

It was practitioners like Bennett, grounded in a different medical cosmology who were prepared to assert the logical implications of the rejection of bloodletting and the change-of-type theory. Their intellectual, affective and social commitments were with the advancing tradition of Clinical-Hospital Medicine, with its orientation of knowledge located in the urban hospital wards, pathology dissection rooms and the physiology laboratories.

"In large measure, the difference between Bennett's therapeutic outlook and that of other leaders of the profession stemmed from educational differences".(83)

These differences produced competing conceptions of the relationship between medical research and medical practice. This, in turn, generated different conceptions of the authoritative source of and validation of medical theory.
For Alison, bedside clinical observation and therapeutic practice changed medical theory. For Bennett, the interaction of clinical experience with the experimentally derived theory of the laboratory, change medical practice.(84)
Thus, although they were inheritors of the occupational tradition of regular medical practice, that practice was being transformed by the innovations of medical theory grounded in more systematic research in anatomy, physiology and pathology exemplified by the Paris School of

Clinical-Hospital Medicine.(85) This included a patho-physiological conception of 'inflammation', rather than one based on a symptomological natural history of the clinical entity. So in a sense they were incommensurable in some areas of knowledge. Yet this condition is, to my mind, directly related to the specific socio-cognitive and affective attitudes of the protagonists. It certainly seems that to a large extent, substantive incommensurability over the phenomena of 'inflammation' was not helped any by Bennetts sarcastic, condemnatory and antagonistic attitudes towards Alison and others of the older school of thought. Together, with his sceptical and critical experimentalist attitude, we have the makings of a medical dogmatism and dogmatist, equally as intransigent as the supporters of Heroic medicine.(86) Allied with a therapeutic scepticism based upon a critical, experimental empiricism, the previous certainties of theory and practice, within the Heroic-Bedside Cosmology, were radically shaken and eventually replaced and transformed by new certainties. In addition to the inner transformations and replacement of Heroic-Bedside Medicine by self criticism and innovation were the critical attacks mounted by the various non-heroic marginal and non-regular practitioners in Britain and the United States during, and throughout, the nineteenth century - most notably the homeopaths but also including Thomsonians and Eclectics in the United States of America; hydropathists, mesmerists and various naturopathic/

herbalistic groups in Britain.[87]

3.5 Clinical-Hospital Medicine (1830-1880)

The French Revolution of 1789 ushered in an era of expanded, government directed, state financed science under Napoleon (1769-1821). One aspect of this programme was the replacement of medical personnel killed during the Revolution and the improvement of practical surgical skills and knowledge. This was especially necessary in the face of a long and extensive, European-wide campaign. After all, with limited personnel for military purposes it was important that those who were damaged by warfare be 'repaired' and returned to the theatre of war. This is not to draw a direct, or even a deterministic, link between the rise of the Paris School of Clinical-Hospital Medicine and Napoleonic military requirements. However, it is to indicate that the emergence of such a school and such a research programme, based upon Giovanni Battista Morgagni's (1682-1771) morbid anatomy researches, was not purely coincidental with such military and political requirements.

The anti-metaphysical, anti-clerical, materialist aspects of the French (Cultural) Revolution provided the intellectual basis for the emergence of the sensationalist epistemology of the Idéologues, such as Cabanis and Destutt de Tracy. This was developed from the mid-eighteenth sensationalism of Etienne Bonnot de Mably de Condillac

(1715-1780).

Condillac had been a disciple of John Locke's empiricism and via him the Idéalogues developed a union of passive sensationalistic psychology and analytical empiricism which provided the philosophical orientation of the Paris School of Clinical-Hospital Medicine.(88)

Other changes conducive to the emergence of Clinical-Hospital Medicine were,

"the compulsory closure, during the revolutionary period, and the subsequent reorganization, of the institutions of medical education, the effects of war, the breakdown of the rigid distinctions between physicians and surgeons, and the development of the hospital system in Paris".(89)

The Paris hospital system was partly due to the interest of Cabinis and the minister of education in 1794 (after the fall of Robespierre), Garat, who was also an Idéologue. Cabinis was encouraged by Garat to present his views for the reform of medical education. This work was only partly completed by 1795 but was first published in 1804. But it was the work of Thouret, Fourcroy and Chaussier which established the new clinical teaching at Paris, Montpellier and Strasburg. In Paris, three hospitals were linked with the new medical school...

"These were L'Humanité for external diseases, L'Unité for internal diseases, and most interesting of all the Clinique

de perfectionnement, or Hôspital des cliniques, for rare and complicated cases".(90)

The latter hospital was not only for teaching but also research and experimental therapeutics. However, this original aim was not fulfilled and by 1815 it had become a surgical hospital.(91)

The Paris School created the medicine of (clinical) observation on the basis of the (sensualist) philosophy of observation. In other words it was based upon physical examination by hand and ear, on pathological anatomy, statistics, and the concept of the localised lesion. In the context of the hospital wards and dissection rooms the occupations of physician and surgeon were united into a set of distinctive practices which quickly labelled Paris as the innovative 'Mecca' of 'modern medicine' within a generation of opening in 1794.(92)

The hospitals provided the physical, social and organizational framework for the elaboration of Morgagni's exemplary work in morbid anatomy and the application of critical analytical empiricism, in the Lockean tradition, to clinical diagnosis. Indeed, it is true to say that,

"It was only in the hospital that the three pillars of the new medicine - physical examination, autopsy, and statistics could be developed".(93)

Certainly, one of the most important changes in clinical method brought about by the Paris School was the shift from symptomological observation - which depended so much upon the patient's verbal reports of subjective symptoms - to actual physical examination of the patient. This had its own problems to contend with, especially the problem of access to the patient's body and private information about the patient's 'activities'. The reason that clinicians working in the Paris School found little resistance to such 'access' issues was because they were not being paid by the client/patron, or working in privately financed and controlled charitable institutions, as in Britain. Thus the individual lay patron, or the collective lay board of hospital governors could not 'dictate' to the physician/surgeon who could be treated and how. The patients of the Paris hospitals were the urban poor who had been used to a rather 'callous' kind of life in the slums and poor rural areas. Thus, there was a marked difference in status between the patient and the physician/surgeon, to the latter's advantage, and a different attitude to the body in comparison with 'genteel' society.

One important consequence of this situation was that the urban hospital patient, unlike the previous heroic-bedside patrons, was no longer able to define the illness or the appropriate therapy. These were now under the control of the physician/surgeon. This situation began to pertain

increasingly so from the 1858 Medical Act in Britain and the Medical Education reforms during the 1890's in the United States.

"As a result, the emphasis in medical research was now able to move away from problems of therapy - which were of course, of prime interest to the patient - to the more basic problems of the diagnosis and classification of disease".(94)

3.5.1 The Tools of Clinical Medicine

The development and refinement of existing tools and the origination of new tools is very important for the investigation of known subjects of a field of inquiry, the general definition of the problems to be studied, the direction of research and the production of entirely new sorts of data and information .(95)

Tools of various kinds were important in the elaboration of clinical methods and its substantive knowledge. Since medicine is a complex applied science drawing knowledge, tools, techniques and methods from other more basic disciplines such as general biology, anatomy, physiology, chemistry, surgery and pharmacology, its theory and practices are given their particular style, tone and direction relative to certain knowledge (or tool) providing disciplines which gain epistemic, occupational or educative dominance within the total professional cultural complex. In the Paris School the dominant basic disciplines shifted between

anatomy (including morbid anatomy), physiology and pathology. However, the focus upon local lesions, clinical observation and correlation of the latter with the former in the dissection rooms stayed fairly constant. Surprisingly, the therapeutic aspects of the Paris School varied widely between scepticism, active interventionism and eclecticism at various times. (See diagram 4, Appendix 1). Within this complex, developing situation certain physical and intellectual tools were consistently employed. There was the use of medical statistics, clinical thermometry, hypodermic injection, microscope and stethoscope.

(i) Numerical Method

Vital statistics based upon census information had been known of from antiquity but the first book on the subject was written by John Graunt in 1662 entitled "Natural and Political Observations upon the Bills of Mortality". However, it was Pierre Charles Alexander Louis (1787-1872) who established the use of statistical methods upon medical data in any consistent and systematic manner - although other clinicians of the Paris School had used statistics in a piecemeal way. [He was also the first to use the pulse watch (see below), after Sir John Floyer (1649-1734), in physical diagnosis].

In order to demonstrate the non-validity of Broussais' system, which had gained therapeutic ascendency in the

Paris School between about 1816-30, he conducted five hundred post mortems prior to publishing his refutation of the system (1835), demonstrating the numerical method and the unfounded basis of bleeding in the case of pneumonia.[96] Statistics at this point in time were simple numeration, averages, percentages and ratios and nothing like the highly sophisticated contemporary discipline.

(ii) Clinical Thermometry

The medieval pulse-watch was revived in the eigteenth century by Sir John Floyer (1649-1734). However, the quantitative and qualitative aspects of pulse-taking were both used in the Paris School. It wasn't until 1849/50 that Sir William Thomson (Lord Kelvin) established the Kelvin scale of absolute temperature and that he, Clausius and Helmholtz had worked out the mathematics of heat transformation that the quantitative aspects of clinical thermometry could become more dominant. Yet, not until 1868, when Carl Reinhold August Wanderlich (1813-77) published his work on the relationship between disease and animal heat, did clinical thermometry become a recognized aspect of clinical diagnosis, especially in the case of fever.

(iii) Hypodermic

Intravenous injection of drugs had been experimentally used in 1656, with blood transfusion between 1665-67. Anatomical

injection had been accomplished by Jan Swammerdam (1637-80) and others during the seventeenth century. Preventative inoculation was pioneered in 1770 by Edward Jenner (1749-1823) and provided the first written account of an experimental demonstration of its effectiveness in the case of smallpox. Further to these techniques was that of hypodermic injection, using a gravity device, for pain relief in the mid-nineteenth century, by Francis Rynd (1801-61).

(iv) Microscopy

This had been developed, in an experimental way, by many amateur natural philosophers in the seventeenth century.(97) Its use as a tool was extended very slowly into disciplines other than 'natural history'. Its technical sophistication and precision was steadily improved, particularly in 1830, with Joseph Jackson Lister's improved achromatic lens for the compound microscope.

The application of microscopy to classical anatomical (non-microscopic) tissue analysis in the tradition of Bichat, by the pupils of Johannes Muller (1801-56), such as Schwann, Henle, and Virchow, rapidly benefited the study of histology and the pathophysiology of cells during the 1840's. Thus, by this time the centre of gravity in the medical world was shifting towards Germany and the application of a far more radically reductionist philosophy of science in medicine and its ancillary basic disciplines of physiology,

pathology, neurology and so on.[98]

(v) Stethoscope

Besides expanding the substantive knowledge of the disciplines of anatomy, pathology and physiology during the first half of the nineteenth century, the stethoscope was an original and novel innovation in physical examination. It was the use of a piece of rolled-up paper by Réné Théophile Hyacinthe Laennec (1781-1826) in 1819 which led to the use of auscultation and percussion in the diagnosis of pulmonary diseases.[99] In 1819 he published his "Traité de L'ascultation médiate" which was republished in 1823. This work made Laennec famous and became the basis of modern knowledge of chest diseases and their diagnosis by mediate exploration.

3.5.2 Philosophy and Therapy

In themselves these tools have no special significance, but in the context of the programme of clinical research and the production of reliable, empirical medical knowledge based upon anatomic, physiologic and pathologic investigation they constitute part of a configuration of thought and practice which provided the foundation for modern clinical research and practice during the remainder of the century and beyond. This was the distinctive accomplishment, in the long term, of the Paris School of Clinical Medicine. However, in the short term, the practical import and

relationship of physiological knowledge to therapeutic practice was hotly debated well into the last decade of the nineteenth century. As far as practicing physicians were concerned its impact was to replace what it had removed in therapy with little, if anything, at all. It had certainly begun to remove the abuses of bleeding, leeching, purging and stupefying in Heroic medicine but replaced them with, on the whole, a sceptical therapy which moved between the conservatory expectancy of Bichat, the heroicism of Broussais and eclecticism of Louis and Andral.

The philosophy of observation, clinical diagnosis, physical examination, dissection and medical statistics resonated well in the post-revolutionary milieu of France and also in the United States with its liberal foundation and lack of long sedimented institutions and cultural traditions. Here the pupils of Louis, Laennec, Chomel and Andral propagated the gospel of the 'medicine of observation'.(100)

In England, physician-physiologists were equally as competent as their French counterparts in applying physical and chemical methods to organisms. However, the xenophobia of early nineteenth century Britain, particularly the French (i.e. Jacobin) variety, constrained the explicit, public involvement of physiologists in the abstract theological-philosophical-political debates over atheism and materialism, of which continental clinicians, particularly French ones, were accused.(101) In Britain,

"it was patients, not problems, that occupied them".(102)

Greater involvement was to come in the public issues of free thought and non-conformity in the wake of the 1832 Reform Act.

With the declining influence of Heroic medicine upon medical education in Britain and the United States of America during the first half of the nineteenth century and the increasing influence of the patho-physiological and clinical approach of the Paris School, a decided effect upon certain aspects of therapy occurred.

Courageous and far reaching criticism of heroic therapy began to be made during the 1830's and 1840's by the newly trained hospital clinicians. In America, for instance, Jacob Bigelow, argued in 1835 that many diseases...

"ran a course to recovery or death that could not be altered significantly by the efforts of physicians".(103)

The conclusion drawn by Bigelow was that the patient should not be made to suffer more from the employment of useless therapies. Such self-limiting diseases as he identified were whooping cough, measles, scarlet fever, smallpox and other eruptive diseases. It was this practical aspect of his address on self-limited diseases which was emphasized in reviews rather than the reorientation of therapeutics recommended by his medical philosophy.

Oliver Wendell Holmes (1809-94) was an eminent critic of heroic therapeutics but even he, in the 1860's, still retained several drugs including arsenic, mercury, cinchona, opium, wine and anaesthetics. He was interpreted as recommending that all physic should be thrown away. In fact he had only said that...

"if the whole materia medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind - and all the worse for the fishes".(104)

As internal criticism mounted from sceptical physician-clinicians as to the efficacy of heroic therapy generally and bleeding, leeching, blistering and overdosing in particular, regular practitioners were increasingly faced with one of three choices. First, copy the 'successful' aspects of the medical practices of their 'deviant' competitors. But this would leave the regulars with no distinctive goods and services except the gentlemanly bedside manner, which the professionally trained homeopaths had anyway. Second, advocate therapeutic nihilism/scepticism and just let nature take its course with minimal assistance from the practitioner. In effect this would mean that after a proper clinical diagnosis had been made the prescription would include some moderate but nutritious diet, plenty of light, fresh air, fresh water, rest and moderate exercise. But if this were the case then the legitimacy of the professional practitioner was severely

in doubt. After all, no special training or knowledge was needed to administer such therapies. Could practitioners afford to actually, consistently practice such a non-active therapeutics? In practice few, if any, practiced such a regimen. Third, modify heroic practices (see 3.5.3). This continued well into the last three decades of the nineteenth century. Such scepticism, even nihilism, was understandable when advances in pathology, physiological experimentation and surgery seemed to be made almost every day,(105) whereas therapeutics seemed to have little to give in the way of positive cure for specific diseases and illnesses.(106) This situation continued until the efforts of the bacteriological research programme, crystallized by Koch, began to bear fruit in the 1890's with Behring's diphtheria antitoxin which could be commercially produced for the medical care system. The practitioner response to therapeutic scepticism and nihilism was a neo-vigorous, or eclectic, therapeutics.

3.5.3 Neo-Vigorous Therapy

Under pressure of patient demand to 'do something' practitioners continued to use symptomological criteria as to the appropriate therapy. In other words, therapies which 'made an impression' on patient symptoms were selected to form part of the armamenturium of regular practice. Heroic bleeding, leeching and blistering rapidly declined in the second half of the nineteenth century but,

"Drugging continued to be the watchword in [American] medicine in the second half of the century".(107)

As Rothstein correctly states,

"New antipyretics continued to reduce fever at any cost. Analgesics and anodynes continued to relieve pain and hypnotics to induce sleep despite their addictive properties and other undesirable side effects. Stimulants were widely employed to strengthen the pulse and improve appetite and digestion, when their long run effects were deleterious in the extreme. Throughout the period, harmful drugs made the presence of the physician a dubious advantage in much medical care".(108)

(i) Tonics

Arsenic was replaced by quinine and then by strychnine as a stimulant. The latter had little therapeutic value, besides being a poison. Beverage alcohol - whisky and brandy - was used as a stimulant to the digestion and heart. It was used in both chronic and acute cases of diseases, such as typhoid and pneumonia in the latter situation.

(ii) Antipyretics

These were essentially pharmacological substitutes for the lancet of heroic bleeding. Their purpose was to reduce heart action and therefore the pulse. Aconite, veratrum viride and quinine were popular throughout the second half of the

nineteenth century. The alkaloid extract from cinchona bark - quinine - became a virtual panacea during the 1870's and 1880's when it was cheaper to produce than earlier. However, even this was replaced by synthetic antipyretics from coal-tars, such as antipyrine, acetanilid (or anti-febrin) and acetylsalicylic acid (i.e. aspirin). Each had deleterious side-effects when used in quantity or over consistently long periods.

(iii) Analgesics

Pain relief has been a constant problem within all kinds of medical cosmology...

"The most important analgesics during the last half of the nineteenth century were opium and its alkaloid, morphine".(109)

This, like quinine, achieved panacea-like status in therapeutics. Yet regular practitioners seemed indifferent to the addictive properties of the substance, which problem increased with the use of intravenous injection of morphine. By the end of the century, morphine and opium addiction was a major social issue, especially in the United States of America. This issue led to the development of an alternative to opium and morphine, namely cocaine.

3.5.4 Comment

Because of the lack of knowledge as to the causes of

disease (i.e. aetiology) dependence upon symptomatic treatment at the level of practical therapeutics and the negative effects of therapeutic scepticism/nihilism upon therapy, regular practitioners were often little better, therapeutically, than their untrained competitors. They certainly had no special advantage over the professional homeopaths. In fact, quite the reverse was the case as far as comparisons of their respective therapies, in relation to mortality figures, were concerned during the mid-nineteenth century.(110)

3.5.5 Eclectic Therapeutics

Somewhere between therapeutic nihilism on the one hand and neo-vigorous therapy on the other, lay the attempt to formulate a rational synthesis, or compromise, between the two extremes.

One such attempt was made in the prize winning essay of Dr. Worthington Hooker (1806-67) of 1857, entitled 'Rational Therapeutics; or the comparitive value of different curative means, and the principles of their application'.(111)

His essay is written in response to a proposition taken from an address given by Dr. A.A. Gould to the Massachusetts Medical Society in 1855. The proposition was...

" 'We would regard every approach towards the rational and successful prevention and management of disease, without

the necessity of drugs, to be an advance in favour of humanity and scientific medicine'."[112]

Hooker held that this proposition encompassed two aspects of regular medicine - retreat from active medication and prevention of disease via location of its causes and guarding against its action. He proposed to deal with the therapeutic aspects of disease prevention and management, rather than its preventative aspects. Thus, his plan was to illustrate the proposition from recent medical history (i.e. within the previous fifty years), draw lessons from the illustrations to show principles for the guidance of practitioners in their therapeutic investigations, then show how such principles served the proposition of non-interference in medicine and so place therapeutics on a rational basis.[113]

Although Cullen, and his active interventionist heroic medicine, was something of a hero for Hooker, he thought Cullen wrong in opposing the doctrine of 'vis medicatrix naturae' or expectant therapy. With the decline of active (i.e. heroic) medication since the 1830's, the regular profession was able to be more "discriminating... in relation to the operation of remedies".[114]

Sectarian strife within the regular profession over disease causation, (sthenic versus asthenic), therapeutic style (depletion versus sedation/stimulation), and therapeutic

specifics (venesection versus opium and calomel) had deeply divided regulars amongst themselves. However, the thesis that no medication at all would have been better does not lead, Hooker argues, to the conclusion that

"the absence of all medication would have been followed by better results than a judicious application of general principles, - the measures of both modes being adopted to some extent, and adjusted to the needs of individual cases".(115)

So he is in favour of judicious, active intervention in the vis medicatrix naturae.(116) But how much value is it and what are the principles to be employed as guides in fixing the limitations of positive medication in individual cases? For this he turns to medical history to show that...

"All disturbing remedies are much less in vogue now than they were in the first quarter of this century".(117)

Bleeding, and mercurial preparations had been abused but now they were used more 'appropriately' and discriminatingly. The change of type theory had convinced many, including Hooker, that less active, more expectant therapy was appropriate. The change of type thesis (of disease or human constitutions) together with the notion of self-limiting diseases called for less intervention from practitioners, except if complications set in. Then the physician could intervene cautiously and judiciously.(118)

The regular practitioner, according to Hooker, is to now conceive of his role in relation to the recuperative power of nature.[119] This power is to be used by the physician. He can "modify and direct its effects... remove obstacles out of the way of its action... put the system into a condition to receive the full benefits of its efforts... It is seldom that he is called upon to go counter to her operation, and then only temporarily".[120]

In addition to the ethical maxims of Chomel for the physician not to do harm and to do good, Hooker added that of preventing harm being done.[121] On this basis certain principles of medical practice could be proposed -

1. "That no active medicine should be used in any case, unless the evidence is clear that it will effect good".[122]

   (what he called "masterly inactivity".)[123]

2. "the practice in each case should be based mostly upon what we know of the modus operandi of remedies".[124]

3. "Obedience to general principles is inconsistent with the adoption of any exclusive treatment. It leads to liberal eclecticism".[125]

4. "That we should be governed in our treatment of disease by the actual effects which we see our remedies produce".[126]

The chief source of resistance to such discriminatory

principles of medical practice, he argued, was mainly "the profession itself"[127], but also the demands of the public for effective (usually active) medicine. However, although clinical diagnosis was more advanced than therapeutics - especially after the work of Lannnec and the French Medical School - therapeutics had still advanced. Not in the discovery of new remedies but in the limitation of existing remedies, on the basis of more precise clinical diagnosis and comparison, improvement of hygiene to reduce complication and severity of a disease, and use of the numerical method as an auxiliary method of comparing and assessing therapeutic efficacy.

He concluded by summarising his opposition to those who used no drugs at all, relying completely upon the powers of nature; those who used as few drugs as possible, again relying mainly upon nature; and those who indulged in indiscriminate polypharmacy and/or overmedication. He supported a liberal eclecticism, a discriminatory medicine which used the power of nature and only intervened in its natural history when appropriate and tailored the frequency and dosage of therapy to the individuality of the disease and the patients constitution. He judged the French to excel in pathological anatomy, the English to excel in medical literature, and Americans in therapeutics. However, although he proposed a judicious, eclectic therapeutics it was still symptomologically based as to assessing

the effects upon the patient. The basic difference which clinical-hospital medicine from the Paris School had made was to establish therapy on the principle of minimal interference with the natural recovery of the patient. Hooker's version of this was that of 'masterly inactivity', unless definitely warranted.

In its basics, eclecticism was a rationalization by those regular practitioners who desired to avoid the overdrugging, polypharmacy and medical vampirism of heroic-bedside medicine.

They were also impressed by the more exact clinical approach of the Paris School but due to patient demands and status anxieties about occupational legitimacy brought on by therapeutic scepticism/nihilism, wanted to avoid certain implications by advocating a kind of active-expectant therapeutics. Hence, they sought to preserve the status of the regular physician as an occupational and epistemic elite wielding expert knowledge regarding the hidden, inner dynamics of the organism.

Neo-vigorous therapy had a similar justification but failed to avoid the pitfalls of overdrugging and polypharmacy which helped bring about the eventual demise of classical heroicism in the previous half of the nineteenth century.

Essentially, neither gave the regular practitioner a therapeutic advantage over the 'gentle' medicine of

homeopathy. Yet the anti-homeopathic rhetoric would certainly not give that impression to the casual reader.

3.5.6 Conclusion

Of course Clinical-Hospital Medicine was not the sum total of medicine practiced in Paris between 1794-1848. Practitioners from previous generations and traditions co-existed with them. However, these other traditions did not attain to the historically-formative power of the Paris School.

In terms of individual personalities it was far from a monolithic unity. However, such biographical disparities fade into secondary significance compared to the common medical, philosophical tradition uniting their thought and practice, namely,

"to study disease by relating the findings of clinical observation and examination (especially the new methods of percussion and auscultation) to changes found in organs on the autopsy table as the most positive element of medical information".(128)

The emergence of neo-vigorous therapy and medical eclecticism were the practical responses of practicing physicians faced with the fruits of a more accurate clinical knowledge and its pathological correlations in the dissection rooms, and the demands of patients who expected the doctor to actually

do something for them.

Also emerging during the 1830's onwards was an increasing understanding of the causal relationship between disease and micro-organisms. Pasteur's theory of ferments coupled with Lister's application of it in surgical operations brought a great stride forward in surgery and midwifery. At the same time improvements in public health throughout the century stimulated a solution to the Contagionist versus Miasmatist parties in the debate over disease causation. The (temporary) resolutions of that debate in favour of the Contagionists, with Koch's disease entity theory of 1876, crystallized into an international scientific research programme. One to which can be given the name Bacteriological-Laboratory Medicine.

3.6 Bacteriological-Laboratory Medicine (1860-1910)

A further shift in the locus of the production of medical knowledge and its increased standardization came from the university laboratories and research institutes of Germany during the second half of the nineteenth century. German physiological and pathological medicine had become far more reductionist than its French counterpart. It was reductionist in the sense that the concepts and methods of the natural sciences of physics and chemistry applied to the non-animate world were regarded as equally applicable to organic matter. In short the phenomena of biology - organic life - was

regarded as reduceable to the phenomena of physics and chemistry (i.e. ontological reductionism) and that the methods, principles and laws of physics and chemistry were equally applicable to biology (i.e. methodological reductionism).(129)

Histology and physiology were the growth areas in German medical sciences and the discoveries made there were eventually organized into a systematic form in the cell theory of Theodor Schwann (1810-82) in 1839 which was quickly modified and elaborated by other researchers over the next decade. From this developed cellular pathology and and the classic work of Rudolf Virchow (1821-1902) published in 1858 upon this very subject.

The cell was now the basic unit of life - for plants and animals - thus the origin and cause of disease was to be sought in the pathology of the cell.

"Life thus became the process of interaction within and between cells, disease a particular form of these physical and chemical processes".(130)

Yet no new (cellular) therapeutics was forthcoming from such a rapidly growing science. However, a new kind of clinical medicine was being constituted by its advances. Medical knowledge became tied to the analysis of all cellular processes in the search for the causes of cellular malfunction (i.e. disease). The chemical tests of the

physiology-pathology laboratories became the source of medical authority regarding morbific processes in the human organism. Yet the human organism had been dissolved into the chemistry and physics of the search for the fundamental biological 'particles'.

"The search was instituted for the ultimate unit of analysis rather than the highest levels of synthesis".(131)

This search produced an increasing disjunction between medical practitioner and laboratory researcher, with two distinct career systems and two different views of the relation of basic medical science to medical practice developing. The practitioner constantly asked of the researcher's results 'What is their (practical) use to me?' 'How will it help cure/palliate my patients?' After all, consistent, demonstrable therapies were the basis for earning his livelihood.

Throughout the nineteenth century there was a fairly constant debate as to disease causation which was eventually resolved in favour of the animacular contagionists through the exemplary research of Robert Koch (1843-1910). This work was paradigmatic for the constitution of the bacteriological scientific research programme from the mid 1870's onwards.

The theory of disease causation had been a problem for each of the previous medical cosmologies and each had contributed to the debate but from different perspectives of theory and

practice.

3.6.1 Theories of Disease Causation

By the mid-nineteenth century three theories of disease causation were employed in the debates to explain not only everyday illness, but particularly the devastating effect of various epidemics (e.g. Cholera in England in 1831/32, 1848/49, 1853/54). However, the work of Louis Pasteur (1822-1895) in the 1850's and 1860's, followed by the work of Robert Koch (1843-1910) during the 1870's to 1890's became the exemplars for the founding of the bacteriological, scientific research programme during the last three decades of the century. The theories of disease causation were the Contagionist, Zymotic and Miasmatic.

(i) Contagionist Theory: invasion by little particles

This was the argument that diseases were transmitted by physical contact with infected persons, or objects in contact with them. The disease was caused by particles (animate or inanimate) which reproduced in the body. It was an argument of ancient origin which received scholarly formulation in a book, after a pandemic of syphilis in the fifteenth and sixteenth centuries, by Giralamo (Hieronymus) Fracastorus (1478-1553) in his work of 1546.[132] Athanasius Kirker (1602-80) was the first author to argue that such particles were not just animate but also of microscopic size. It was the work of Antonj van Leeuwenhoek (1632-1723) which

established the systematic study of micro-organisms[133], and Dr. Benjamin Marten applied the 'contagium animatum' theory to the explanation of consumption in his work of 1720, "A new theory of consumptions: more especially of a phthisis or consumption of the lungs"[134] which received little attention from medical men of the day.

Investigation into infectious diseases and fermentation during the 1830's and 1840's was crucial to the development of the contagion theory. For example, in 1835 Agostina Bassi (1773-1856) demonstrated a causal relationship between a specific micro-organism[135] and a specific disease of the silkworm. He generalised his findings to human disease but could not proceed due to the lack of technical developments in the resolution powers of microscopes, and the lack of fixing and staining techniques for pathogens. However, despite these problems the study of microscopic fungi in plant pathology did make some advances in the 1840's such that researchers accepted the idea that certain plant diseases were caused by micro-organisms.

In 1840, the German histologist Jacob Henle (1809-85) published his work "On Miasms and Contagia" which synthesised previously unconnected experimental work on micro-organisms. From this he concluded that the causal agents of disease were animate micro-organisms. In this study he set out principles for research into the aetiology of disease. First, that there should be a constant association

of specific micro-organisms with specific diseases. Second, that the pathogenic "contagium animatum" should be isolatable and third, that it must be possible to reproduce the disease with it. It was certainly not coincidental that Henle's pupil, Robert Koch (1843-1910), produced similar principles in 1882 (modified in 1884) following upon his work on the anthrax bacillus published in 1876 and the discovery of the tubercle bacillus in 1882.(136)

Henle's principles also influenced the work of Louis Pasteur (1822-95) whose work on the processes of fermentation and putrefaction in the production of wine, vinegar and beer produced the fact that they were not purely chemical actions but that the yeast organism was absolutely necessary for their production and that other organisms could sour the wine, or beer.(137) During these investigations Pasteur developed a process of rapid heating of wine to 55°C,out of contact with air, to kill the bacteria - i.e. pasteurization. This process was later applied to beer and milk.

It was he who experimentally demonstrated the falsity of the ancient doctrine of spontaneous generation in 1862.(138) Another of his important investigations, relevant to the contagion theory of disease, was that into the diseases of silkworms. By 1861, the French silkworm industry had been virtually decimated by an epidemic disease and Pasteur began work for the Minister of Agriculture, investigating the

silkworm disease problem, in 1865. It took him five years to produce results demonstrating "how certain diseases in silkworms could be avoided".(139)

Such investigations and arguments by such as Henle, Pasteur and others played a crucial role in convincing many medical practitioners that some human diseases were caused by specific micro-organisms. Many, of course, just could not accept that such minute living particles could cause disease in human beings. Some argued that the observed micro-organisms were the effect of the diseases, rather than their cause. Others argued that they were secondary invaders following upon the disease proper. Some held the micro-organisms appeared 'de novo' upon the debilitation of the human organism. Thus, despite increasing evidence, especially Pasteur's work on fermentation, putrefaction and silkworm disease, the theory of disease causation by micro-organisms could not be empirically established due to both theoretical, experimental and technical obstacles - in microscopy and staining methods - which were not solved until 1875.

(ii) Zymotic Theory: things in ferment

This was a compromise between the contagion and miasmatic theories of disease causation and was based upon the analogy between fermentation and infection processes which could result in putrefaction. Thus Pasteur's work on fermentation and putrefaction in wine and beer provided some evidence for

it. By analogy the infectious material was thought to have the properties of a ferment or zyme (the modern term being 'enzyme') specific to each disease. This zyme was said to multiply within the living organism and thus produce the disease specific to it. But no-one succeeded in demonstrating any such zyme until the work of Edouard Buchner in 1897 succeeded in producing 'zymose' from yeast juice, an agent capable of producing fermentation of alcohol from certain sugars.(140)

(iii) Miasmatic Theory: stinks, sewage and sanitation

This too was an ancient doctrine which helped people to understand the causes of epidemic diseases. It replaced the theory that diseases were due to supernatural causes or divine judements. Pestilence began to be explained by reference to natural causes such as comets, earthquakes and "changes in the air which was believed to be polluted or defiled by 'miasms' (μιασμσ, stain)".(141) This view of disease causation by 'foul' airs particularly held sway over other theories during the periods of humoral medicine, such as that of heroic theory and practice. It was generally supported by anti-contagionists and helped shape public health reforms up until the 1880's.

During the nineteenth century, with the urbanization of Britain, Europe and North America it is surprising that the problem of human and animal excrement continued so long in

view of the dominant miasmatic theory of disease causation[142] which held that...

"diseases arose spontaneously from the miasma, or effluvia or noxious gases emanated by accumulated organic matter. Put simply, bad air from putrefying matter vitiated health and produced disease...

The pythogenic view focused attention on the sanitary state of things, and although the theory of the propagation of disease which it advanced was incorrect, it nevertheless achieved much good"[143]..... - in the form of sewer construction, sewage disposal and local boards of health.[144]

"That smell and stinks caused disease was not proven, but where excrement lay there also were breeding grounds for disease-carrying flies and air, and water-borne germs. Although the effluvia theory offered little stimulus for empirical biological research, by its stress on a pure environment it encouraged the public health movement and the sanitary reforms we associate with Edwin Chadwick".[145]

3.6.2 Comments

Of course, these three basic theories of disease causation had their own variations. For example, the zymotic/ fermentive theory could be understood from a contagium animatum or a miasmatic-chemical position. Some, like Henle, proposed in 1840 a kind of developmental pathology

of the causative agents of disease (at least he can be interpreted as such).

"He regarded contagion as a kind of miasm in the second generation - a miasm which had passed through its first development in the human body. In the miasmo-contagious diseases the contagion is known to be eliminated from the body and conveyed to the healthy either by the atmosphere (volitile contagion) or by contact (fixed contagion).....

Henle clearly pointed out the difficulties of obtaining proofs that his views were correct".(146)

The resolution of the theories of disease causation outlined above, during the nineteenth century, could not and did not take place until accurate, reliable, reproduceable techniques for isolating and identifying the specific causal agents of specific diseases were available. Thus, the Bacteriological Revolution and the necessary conditions to establish a concomitant research programme were dependent upon the contingencies of certain innovations in microscopy culture mediums and staining of micro-organisms. These contingencies constituted a unique configuration through the research of Robert Koch. Between 1876-78 he established the germ theory of disease, considerably improved staining techniques, culture media and laid down the basic technical procedure for bacteriological research. From this developed therapies based upon microbiological research which began to

establish accurate knowledge of the aetiology of disease and the greater possibility of specific cures being discovered for specific diseases. This is not to ignore the problems created for the bacteriological research programme by the increasing evidence for the existence of non-bacteriological agents (e.g. filterable viruses, the physiological condition of the body, environmental conditions and so on) in the pathogenicity of disease.(147)

3.6.3 Contingencies of a Scientific Research Programme

It seems plain that the emergence of a research programme, such as the bacteriological one, was dependent upon the general state of theoretical and technical knowledge in medical research and practice. Theories of disease causation vied for various kinds of status in the medical world but until specific technical breakthroughs were developed the resolution of practical and experimental veracity of the theories could not be decided. However, the work of Louis Pasteur on silkworm disease and the processes of fermentation and putrefaction stimulated Lister's work in developing antiseptic surgery. The weight of plausibility was beginning to shift towards the contagion theory. However, the final decision was contingent upon specific developments in culture media and microscopy.

(i) Staining

Following upon Schwann and Henle's microscopic study of the

tissues, histology began to advance somewhat as the methods of microtomy[148] and staining were improved.[149] Advances in histology were intertwined with advances in staining techniques. By the 1850's and 1860's several staining preparations were available such as carmine (1849), analin and coal-tar preparations (1856), with the extract of the logwood tree (1863) being greatly improved by the addition of alum (1865). However, the first to attempt the staining of bacteria was Hermann Hoffman (1819-91), professor of botany at Geissen.

"in 1869 he employed both carmine and fuchsia, in watery solutions. Weigert (1871) showed that carmine will colour cocci, but the staining of bacteria as an art really dates from his observations in 1875, when he showed that methyl violet can be successfully used to reveal cocci in tissues".[150]

Thus, by the time Koch was conducting his investigations, as a practicing physician, at Wollstein in East Prussia, into the aetiology of the anthrax bacillus (from 1872-76), the necessary bacterial staining techniques were available. In 1876 he demonstrated the natural history of the anthrax bacillus before an audience of the Institute of Plant Physiology, at the University of Breslau, at the invitation of Ferdinand Cohen (1828-98). The demonstration took from the 30th. of April to the 2nd. of May and established Koch as the founder of <u>scientific</u> microbiological research.[151]

"Realizing the importance of getting the bacteria into a non-motile state, he prepared thin films on cover glasses and dried them. To his surprise the form of the bacteria remained unchanged. He then fixed the preparations with alcohol and applied various stains, the most successful were methyl violet 5B, fuchsin and analin brown ('new brown'). The preparations were mounted in an aqueous solution of potassium acetate or in Canada balsam. The preparations were better than any that had been seen before Koch's time, and many of them were reproduced in an excellent series of photographs taken by Koch with sunlight as an illuminant. He also succeeded in staining the motile apparatus - cilia - of certain bacteria. From now onwards staining methods were rapidly perfected".(152)

This further advance was primarily due to the work of Paul Ehrlich (1854-1915) from 1877 until about 1881, with his work on the staining of blood films.

(ii) Culture Media

Solid, liquid and organic media (vegetable and animal) were in use prior to Koch's anthrax research. Pasteur's observations on fermentation (1857) supported the view that it was possible to obtain pure cultures, (i.e. growths of single, unmixed micro-organisms). However, it is doubtful whether Pasteur's method of the serial 'insemination' of sterile, liquid medium with bacterial material (1860's)

resulted in the obtaining of a 'pure' culture - except on occasion, by accident. This 'Pasteur fluid' was improved by Adolf Mayer in 1869, then by Ferdinand Cohen - the latter befriending Koch and arranging to have his anthrax research demonstrated at Breslau University in 1876.(153)

Various solutions made from vegetables such as hay, turnip and carrot were frequently used, as were milk and (neutralized) urine. Meat extract, as a medium, was only really established by Fredrich A. J. Loeffler (1852-1915) - (an associate of Koch from 1879-84) - about 1881, although it had been Justus von Liebig (1803-73) who had previously used it in the 1840's in his work on fats, blood, bile and meat juice.(154)

"The first attempts to obtain separate cultures of pathogenic bacteria were those of E. Klebs (1873) by what he called his 'fractional method'..... but it is almost certain that he never obtained pure cultures by his method".(155)

"Solid media were used with great advantage by Joseph Schroeter (1872) in his classical work on pigment bacteria. Potato, starch paste, flour paste, bread, egg albumen and meat were all employed by him, and on them he obtained a number of bacterial growths..... No doubt Schroeter obtained pure growths".(156)

However, it was the mycologist Oscar Brefeld (1839-1925) who established (1872) the principle to be employed in the

production of pure cultures. He had realised back in 1868 that it was necessary to sterilize the culture media in order to obtain a pure culture.(157)

The method Koch used in his anthrax research was that of the inoculation of susceptible animals with the necessary infectious material. This method had been established by Victor Timotheé Feltz (1835-93) and Leon Loze (1817-96) in 1866-70 and by Casimir Joseph Davaine (1812-82) in 1872. This was in connection with work on septicaemia. The basis of this method was transfer of infectious material from a previously inoculated animal and Koch transferred such material through a series of twenty mice, with the virulent anthrax bacillus still obtainable from the twentieth mouse.

(iii) Microscopy

To continue from what has previously been stated about the development of microscopy (cf 4.5.1 (iv)) technical problems held up that development until the mid-nineteenth century saw some of them resolved. This enabled the development of histology at the cellular level to occur during the 1840's and 1850's, with Rudolf Virchow (1821-1902) developing cellular pathology from 1847 at the earliest and certainly from 1855 onwards.(158)

The main problems in microscopic research, prior to the mid-nineteenth century, were "chromatic and spherical

aberrations.....although poor quality glass - cloudy and with bubbles - was also troublesome".(159)

The development of achromatic lenses by John Dolland (1706-1761) about 1752-58, solved one problem but the maximum resolution power of the optical microscope was attained with the immersion principle. Robert Hooke had suggested it in 1679 but it was Sir David Brewster (1761-1868) who in 1812/1813 elaborated upon his ideas for the immersion lens. Quite independently, Giovanni Battista Amici (1786-1863) came to the same idea in the late 1840's with an actual immersion lens system being displayed at the Paris Exhibition of 1855.(160)

Further advances in the field were the result of the innovative collaboration of Ernst Abbé (1840-1905), Professor of Physics at Jena University and Carl Zeiss (1816-88), instrument maker for the same university. Abbé, by 1870, had established the theoretical mathematical basis for standardizing the processes for manufacturing microscope lenses. He improved immersion microscopy with his 'homogenous immersion system' such that by 1875 the water-immersion system of Zeiss was available for use by Koch in his studies of anthrax bacillus. By 1878, the Zeiss oil-immersion system was available for his studies on infective diseases.(161)

Thus, all the technical requirements for Koch to investigate and demonstrate the aetiology of specific bacteria were all

available, together, by 1875. Neither he, nor anyone else, could have accomplished what he did prior to that date.

3.7 Robert Koch: Exemplar and Founder of the Bacteriological-Laboratory Scientific Research Programme

Robert Koch (1843-1910) studied medicine at the University of Göttingen under Jacob Henle, his anatomy professor. Under Henle he learned of the criteria that needed to be met in order to have experimentally demonstrated the cause of a given disease. Under the pathologist Fedor Krause he gained a thorough knowledge of microscopy. He qualified in 1866 and after some junior posts in hospitals at Hamburg and Hanover, became a general practitioner. The Franco-Prussian War interrupted this career and afterwards he became restless and studied for a higher qualification in medicine, which he passed in 1872. He settled down to a private practice at Wollstein in East Prussia. His research interest motivated him to set up a small laboratory, next door to his consulting room, with a microscope, incubator, sink, darkroom and work bench.

He read of the work of Pasteur and Lister, and the investigation of anthrax as a research focus. Since anthrax affected humans and farm livestock (cattle and sheep) and since it was spreading amongst animals in his administrative district, Koch began investigating its aetiology and natural history.

"In 1876, Koch showed for the first time that a bacillus bore a specific aetiological relationship to a disease, in this case anthrax".(162)

So it was that, with the assistance of Ferdinand Cohen, a botanist and plant bacteriologist at the University of Breslau, Koch demonstrated the bacteriological cause of anthrax. This work was published in Cohen's journal, - 'Contributions to Plant Biology', - in 1876 as "The Aetiology of Anthrax Based on the Developmental Cycle of Bacillus Anthracis".
This established Koch as "the unsurpassed master of scientific research".(163)

In the process of his demonstration Koch also used solidified gelatin for the isolation of pure cultures. This was the gelatin tube method, at first, but later as a plate method in 1883. With his research and techniques - not only in culture medium but in staining with analine dye - he

"laid the foundation on which all subsequent bacteriological investigation was erected".(164)

The work was accepted by everyone except Paul Bert (1833-86), a Frenchman (and Claude Bernard's favourite pupil), who set out to show, experimentally, that Koch was wrong in his conclusions. However, Pasteur hastened to support Koch's conclusions and did so by meticulous experiments. With such support from Pasteur, Koch's work was finally accepted and

together they had proven the germ theory of disease.

"During the rest of the century, bacteriologists discovered micro-organisms to be the cause of many diseases, including tuberculosis, diphtheria, cholera, typhoid and tetanus. Although these discoveries are often attributed to individual men, actually dozens of scientists throughout the world replicated and improved the original experiments to produce scientifically valid, demonstrable, and consistent results".(165)

In short, Koch had brought into a definite, systematic and testable configuration, elements of research existing prior to his own exemplary work, and which came to constitute the basis for the explication, refinement and extension of a scientific programme of bacteriological research. The site of this research was the laboratory, from which the 'sick person' was utterly removed, except as the practicing physician's concrete source of human sickness. A definite research tradition was established and even in the face of immediate technical problems and anomalies(166), its research workers pressed forward with Koch's programme and vision, which was,

"to eliminate epidemic diseases of man".((167)

In fact, Koch had said that despite certain obstacles,

" 'we should not be deterred from proceeding as far as

available methods can carry us. One should first investigate the problems with attainable solutions. With the knowledge thus gained, we can proceed to the next attainable objectives. Diseases such as diphtheria, which can be transmitted to animals, appear immediately amenable to successful investigation. With a knowledge of comparative aetiology of infectious diseases we can learn to hold at bay the epidemic diseases of man' ".(168)

Thus, the origination of a scientific research programme was not just a set of experimental tools wielded within the framework of the substantive and tacit knowledge of a developing tradition, but also a configuration of commitments wedded deeply to a vision of the possible.

Indeed, although "the immediate reaction of physicians to developments in bacteriology was often hostile"(169) it was nonetheless true to say that -

"In the bacteriological fervour of the years following acceptance of the germ theory, bacteria were assumed to be the cause of almost all human and animal infections. Sometimes bacteria which happened to be present in infectious materials were wrongly interpreted to be the cause of the disease in question. Even diseases later found to be non-bacteriological, such as yellow fever and rickets, were initially given bacterial aetiologies".(170)

Thus 'vision' and commitments to that vision were crucial in

the intellectual and experimental extension, refinement and explication of the foundational research programme, at least for the founders and the first generation of researchers. This vision and programme provided the basic motivation and intellectual framework for the later "serum and chemotherapeutic regimens of the 1890's and 1900's"[171] and advances in immunology. The latter owed much to the researches of Elie Metchnikoff (1845-1916), Emil Von Behring (1854-1917) and Shibasaburo Kitasato (1852-1931), Gerhard Domagk (1895-1964) and Paul Ehrlich (1854-1915) in their search for "magic bullets", and in the twentieth century the serendipitalist discovery, by Alexander Fleming (1881-1955), of 'Penicillium'.[172]

The publicly available fruits of the bacteriological programme can be dated from the discovery of the antitoxin to diphtheria by Behring and Kitasato in 1890 and its successful public (rather than experimental) use as a mass therapy in 1894.[173] However, even this specific therapy was opposed by physicians with counter-evidence based upon clinical statistics which questioned the validity of the bacteriologically diagnosed cases. Yet, eventually (in the United States of America for example)

"Popular demand for adoption of the antitoxin put pressure on government public health authorities who in turn were able to induce physicians to use the therapy".[174]

By this time researchers and clinicians were taking a wider

view of the germ theory of disease as they came to recognise the role of the constitution of the individual in the pathogenic process. This point had been obscured during the 1880's fervour of research following Koch's work on infectious diseases (1878).

"Under the influence of cellular pathology and recent work on immunization and mechanisms of immunity, bacteriologists began to realise that the aetiological agent was only one aspect of the pathogenesis of an infectious disease, and once more to recognize the physiological responses of the body as important factors in the process of infection".(175)

It has been argued that during the 1880's the challenge presented by the germ theory of disease, of discovering pathogenic micro-organisms was so great as to temporarily defer issues about the physicochemical aspects of disease.(176) Thus, the "practical goal of developing vaccines was given priority over inquiry into the body's susceptibility or resistance to infection".(177)

By the end of the nineteenth century bacteriology had developed from research largely devoted to the discovery and description of pathogenic bacteria into a programme with supplementary interests in the disciplines of physiology, biochemistry and epidemiology. Prior to this it had acquired a very clear and effective methodology, an array of proven experimental techniques and a solid record of achievement in elucidating the

aetiology, pathophysiology and biochemistry of infectious diseases. It seems as if the interest in the physiopathology and biochemistry of the 'client' were helping re-establish the 'clinical case' as the 'sick person' once again. But, the centrifugal force of increasing specialization in medicine generally prevented this from occurring until the late twentieth century. This was due in part to the steady collapse of medical positivism under the 'hammer blows' of global inflation and the economic stringencies brought by that, together with the undermining of its plausibility structure by historians, philosophers, anthropologists and sociologists of scientific knowledge.(178)

3.7.1 Hard Core Theory and Methodological Rules

The 'natural' classification of disease had developed from seventeenth century empirical, symptomologically based nosography developed by Thomas Sydenham (1624-89) to the clinical diagnosis of symptoms and physical signs promoted by the Paris School of Clinical-Hospital Medicine and their disciplines. These signs and symptoms were (statistically) correlated with the pathological lesions discovered in the dissection rooms and hospital laboratories. This development culminated in Rudolf Virchow's pioneering work in cellular pathology by the mid-nineteenth century.

Alongside these developments in the clinical diagnosis and prognosis of disease a new emphasis upon the aetiology of

disease (which Sydenham had thought beyond human ability to discover) developed during the eighteenth century with theories of contagion. This, as I have described, culminated in the triumph of the germ theory of disease in the mid-1870's to 1880's.

(i) The Hard Core

"Toward the end of the nineteenth century the name of a disease came to reflect the type of entity thought to cause it, the so-called aetiologic agent, and aetiology soon came to be definitive (i.e. to be regarded as essential) for those diseases for which it was known, and diagnostic categories were refined to reflect the view that the character of a disease was determined by the character of its aetiologic agent, and aetiologic classification became the preferred mode of classification"(179)

Aetiological classification established the germ theory of disease as the ontological conception of the disease entity theory. This was the 'hard core' of the bacteriological research programme and under it a case of disease would be conceived of as an "entity or thing" lodged in the body of the patient or host. Cases of the same type would then be the same sort of entity".(180)

The ontological conception of the disease entity dominant in the bacteriological programme conceived of the disease as localised and dislodgeable from the host.

"Thus it has some of the cardinal properties of an ordinary physical object".(181) Thus it is quite unlike bruising or inflammation, which may be localized but cannot be dislodged, by a toxin or serum for instance.(182) The methodological rules - Koch's postulates - were slightly modified by the mid-1880's to begin to account for filterable viruses. The development of immunology, cytology, protozoology, micro-biology and biochemistry functioned to both temporarily protect the 'hard core' so the programme could be established and later - from the 1890's onwards - help to orient and modify the germ theory to include filterable viruses and hence develop the science of virology in the early twentieth century. The increasing attention to technically 'invisible microbes' (i.e. the bacteriophages) was still motivated by the search for therapeutic weapons in the war against bacteria. It took the development of molecular genetics and the electron microscope (1939) to remove the category of 'invisible entities' from micro-bacteriological research. However, the therapeutic intention of bacteriology remained (<u>to discover specific antidotes to specific disease agents</u>) even as its objects of study became more and more microscopic and closer and closer to the characteristics of non-living phenomena. In other words the technical capacity to control or intervene in the process of disease was ever the intention of aetio-logical knowledge.(183)

(ii) The Methodological Rules: Koch's Postulates

Following upon his work on the anthrax bacillus in 1876 and then infective diseases in 1878, Koch produced a paper (in 1881) on the methodology of obtaining pure cultures of organisms by using liquid gelatin with meat infusion upon glass plates, thus forming a solid medium. The following year was marked by the discovery of the tubercle bacillus using special staining, fixing and culture medium methods. During this work Koch formalized the criteria needed to demonstrate unequivocally the causal link between a specific aetiological agent and specific disease signs and symptoms. His postulates, reminiscent of those criteria proposed by his histology and pathology teacher, Jacob Henle (cf 3.6.1 (i)), were as follows. First that the specific micro-organism must be shown to be invariably present in all cases of the disease. Second, the micro-organism could be isolated and cultured in a pure state in an artificial medium. Third, when the pure culture is introduced into healthy, susceptible animals the disease must be reproduced in them with all its characteristic symptoms and properties.(184)

However, in practice the postulates were not easy to achieve in all cases. For example, John Brown Buist in his 'Vaccinia and Variola' (1887) failed to meet the third postulate in his research on vaccines. His 'spores' were observable, when correctly stained, under the microscope, but were probably the viral particles of smallpox and vaccinia,

which he mistook for bacteria in an earlier stage of their development.(185)

Similar findings led to the postulates of 1882 being modified, in 1884, in the light of his own research on cholera for the German Cholera Commission (he visited Egypt and India) in 1883. He now argued that.....

"a bacterium could be accepted as the cause of an infection, even though the disease had not been artificially produced in an experimental animal" (186) which effectively negated the third postulate.(187)

Such methodological modification was triggered by a certain amount of 'concept stretching' which had to occur as the programme began to face the issue of non-bacteriological aetiologic agents, (filterable viruses and so on) during the last decade of the nineteenth century.(188) Such 'anomalies' were constituted by the attempt to apply the postulates in all experimental cases designed to demonstrate the bacterial aetiology of disease. Such modification was a creative, progressive shift, since fruitful new areas of research were opened up in parasitology, protozoology, immunology, cytology and biochemistry.

Even Koch experienced difficulty with the principles and 'promise' of the bacteriological research programme. In 1890 he announced that he had developed a therapeutic agent against tuberculosis, a substance he called tuberculin -

a protein derivative of the tubercle bacillus. The news soon spread and his laboratory was besieged by physicians and their patients. Disillusionment and tragedy followed Koch's somewhat premature announcement. Some patients died from the claimed antitoxin, tuberculin. Although public opinion soon turned against Koch when tuberculin was found to be therapeutically useless, his discovery was not in vain. Tuberculin was found to be useful in a diagnostic test regarding tubercular patients. Also, in 1892 the 'Institute of Infectious Diseases', in Berlin, of which he had become Director in 1891, was re-named the 'Robert Koch Institute' in honour of his discovery of the tubercle bacillus.(189)

This setback was only temporary. He, his students and co-researchers "fought many other diseases, including cholera, malaria, rinderpest and plague. His methods were exploited successfully in the search for the agents of typhus, leprosy, ray fungus, erysipelas, diphtheria, tetanus, pneumonia, cerebro-spinal meningitis, dysentery, relapsing fever and other diseases".(190)

3.7.2 Practitioner Response and Therapeutic Practice

Between 1876-1882 in the United States of America, the germ theory of disease received a fairly hostile reception until "Koch's demonstration of the tuberculosis bacillus and the statement of his postulates in 1882".(191) After which, hostility quickly changed to support and opponents of the

germ theory found themselves in a hostile environment when presenting papers opposed to it. The work of Pasteur and Koch began to carry the day, probably as more and more practitioners and students received medical training in Germany and France, and had opportunity to pursue bacteriological work.

Initial resistance was probably due to many factors, not least that of,

"the average physician's distrust of most scientific medicine",(192)

also that its therapeutic applications (i.e. as direct intervention in the disease of the patient) were not obvious. Although its direct application in preventive medicine was acknowledged.(193)

Finally, that

"nineteenth century bacteriology raised more methodological and substantive questions than it answered, so that its findings were often based on less than conclusive evidence. Scepticism was neither irrational nor reactionary; it was a reasonable position, taken by many leaders of the profession".(194)

It is interesting to note that the basic criteria being employed here by practitioners of regular medicine was that of practicality - does it benefit sick people? (i.e. does it work?). This was precisely the criteria that Hahnemann had advocated his opponents use to assess the efficacy of

homeopathy. They declined and employed purely theoretical objections and ad hominem arguments. Now, after several decades of sceptical and eclectic therapeutics and the failure of pathophysiological research to replace older heroic therapies with more effective ones, regular practitioners seemed to be more interested in the practical applications and implications of research than in purely theoretical rationalistic arguments.

However, I doubt whether this practical concern was new at all. Even under the constraints of the heroic-bedside medical cosmology the concern of the 'regular' and 'irregular' practitioners was the effecting of beneficial change in the medical condition of the patient, as defined by symptomological improvements towards the normal equilibrium of psycho-somatic functioning understood in humoral or solidist terms.(195)

With the clinical-hospital medical cosmology, symptomological change was subordinated to improvement in the physical signs of illness elucidated by prior clinical diagnosis.

One of the more general effects of bacteriological knowledge upon the practices of professional doctors was increased consciousness of "the importance of cleanliness and sterility in all their relations with patients"(196) But as to the exact procedures required to achieve sterility there was still much ignorance.

Therapeutics was affected only slowly in the last three decades of the century. It remained sceptical, expectant and conservatory in its treatments. In the treatment of specific infectious diseases, for example, William Osler M.D. in his work of 1892 "The Principles and Practice of Medicine", advocated a limited range of therapies. Of the forty-two infectious diseases discussed he advocated only 6 specific curative treatments for 6 specific diseases.(197) Of the rest they were either incurable or self-limiting. Depending upon the diagnosis, symptoms and prognosis, Osler's conservatory but sceptical therapeutics advocated good nursing care, bed rest, proper diet, hydrotherapy, ice packs of various kinds, hot poultices, hygienic measures, quinine, or morphia injections for pain relief, alcohol stimulant, some purgatives (e.g. in mumps and measles), soothing lotions (e.g. for chicken pox and scarlet fever), comfortable bed and sleeping attire, seclusion or segregation (e.g. lockjaw, rabies, whooping cough, influenza), sometimes venesection (e.g. mumps and lobar pneumonia), sometimes leeches (e.g. mumps), castor oil, mineral waters, thermo-cautery and anti-septic treatment (e.g. tetanus). The emphasis in virtually all the specific infectious diseases was upon the conservatory therapies of bed rest, diet, hydrotherapy, fresh air, opium/morphia, hygiene, cold packs and hot poultices. He does, of course, state the therapies recommended by other practitioners but either remains impartial as to their efficacy, or admits he has had little or no success with them, or says he has no

experience with them, or gives a definitely negative evaluation of them.(198)

Like the homeopaths he was against polypharmacy and the use of drugs for the sake of using drugs. This progress he attributed to two factors - the sceptical spirit of the clinical-hospital school of medicine in France, Germany and America, and the lessons learned from the harmless infinitesimals of the homeopaths.(199) To my mind, equally important factors were the growth of national education systems, the increasing success of 'professional/regular medical practitioners' in gaining increased status and legitimacy by deploying the rhetoric of science(200) and the increasing standardization of scientific and medical knowledge. These produced improved general, medical and science education through centrally controlled higher education facilities and improved standards of certification. The fruit of research in bacteriology, chemotherapy and microbiology however, were to be reaped by the medical profession of the twentieth century as far as therapeutic specifics were concerned. Even so, it has been argued that the greatest immediate improvement in public health was founded upon the tireless work of sanitation engineers in constructing sewage systems, draining marshland and purifying drinking water; also the improvement in domestic living conditions, nutrition and general standards of living.(201)

3.8 Comment and Thesis

The above chronology of developments towards the creation of the Bacteriological-Laboratory Medical Cosmology emerges as crucial to the thesis that prior to the date of 1875 a systematic, experimentally based, scientific therapeutics had not emerged. Until Behring, prior to the 1890's therapeutics was based largely upon symptomological criteria of 'effectiveness' and could only develop in a trial-and-error way. Between the 1850's and 1890's physical criteria of clinical diagnosis were also used but contributed little to effective, interventionist therapy.

Under Heroic-Bedside Medicine the aetiology and means of contagion of diseases, the relationship between their theories of medicine, their therapies and the actual disease states had no scientific basis.

Even with the emergence of Clinical-Hospital Medicine, the decline of heroic therapeutics, the development of a sceptical, then a neo-vigorous and eclectic therapeutics for much of the second half of the nineteenth century, symptomological criteria of the 'effectiveness' of therapies continued well beyond the discoveries of Koch and other researchers in Bacteriological-Laboratory Medicine. Even (Sir) William Osler (1849-1919) in his 'Principles and Practice of Medicine' of 1892, was still a therapeutic sceptic and

recommended only six therapies he considered medically effective.(202)

Only after 1875 was an effective therapy for a specific disease actually available and based upon the testable, reproduceable, experimental knowledge of the aetiology of the disease. Granted vaccination against smallpox was available prior to this time but its aetiology and pathology was not really known and it was often neglected as a practical therapy.(203) Only with such knowledge could a systematic research programme in bacteriology be established and used to discover specific therapies for specific diseases, or enable the natural history of the disease to be interfered with by pharmacologic, or environmental means (i.e. affecting one of the disease vectors).

Following from the thesis regarding the ineffectiveness of therapeutics and the immaturity of its evaluative criteria regarding disease causation, diagnosis and prognosis prior to the Bacteriological Revolution, the question has to be raised that if that was so, what was the actual basis for the claimed 'scientific' refutation of homeopathy prior to the 1870's?

The answer to this question should be discernable in outline by now, given the monopolisation - marginalisation thesis and the basic medical cosmologies constituted by the thought and practices of regular practitioners and modified by the

shifting centres of medical excellence throughout the nineteenth century.

What follows are selections from the history of homeopathy in Britain and the United States of America, followed by a sociological analysis of that history and the ideological construction of the homeopaths as medical heretics and homeopathy as a medical sect. This will enable us to understand how the contemporary facticity of regular medicine and deviancy of homeopathy, was achieved and sustained. Provisionally, the historical sociology of the rejection/refutation of homeopathy was not scientific (in the sense indicated above) but ideological. Ideological in that the marginalisation of homeopathy was derived from occupational and socio-political collective interests focused by status anxieties, threats to the socio-cognitive plausibility structures of medical thought and practice and the issues of occupational boundary defence (e.g. licensure and certification). These collective interests and issues interacted in such a way as to bring about - whether intended or unintended - the increasing monopolisation of the medical market by the regular practitioners, the necessary marginalisation of homeopaths in that market and their sustained delegitimation as a scientific therapeutics. The evaluations made by regular practitioners under the heroic and clinical medical cosmologies during the 1830's - 1860's were constantly reproduced for the rest of the century and well into the

twentieth century.[204]

Over the whole span of the nineteenth century in Britain and the United States a general movement from a person to an object orientated medical cosmology is apparent. Along with the increased standardization of medical knowledge went a shift in the linguistic basis of the esotericity of such knowledge, from Latin to scientific concepts, terminology, technique and research laboratory. Also the locus of power in defining disease and professional behaviour shifted from the lay patron/patient to those of collegiate peer review and state, third party representation.[205] All in all, radical changes were effected in every aspect of medical knowledge, 'regular' therapeutic practice, occupational career structure and medical care delivery system. It was within these shifting contexts of medical cosmology, medical institutions and politics that the professional homeopaths had to respond and create a social and occupational niche for themselves.

It is those relationships and responses which we will now turn to.

CHAPTER FOUR

HOMEOPATHY IN THE UNITED STATES: SELECTIONS FROM THE HISTORY OF MEDICAL MARGINALS

4.1 Introduction

It is not my intention to provide a detailed narrative history of professional homeopathy in the United States. If such detail is required then I refer the reader to the works of Coulter, Kaufman and Rothstein[1], who deal specifically with that issue in detail, whatever their ideological weaknesses.[2]

However, it is my intention to select specific persons and events in so far as they are agents and bearers of important ideological and institutional conflicts and compromises. Processes of stigmatization and marginalization were both medium and outcome of this conflict, as the regulars pursued internal reforms in order to effect occupational closure against all non-regular practitioners and professional domination of the occupation and medical division of labour.

4.2 Background to the Rise of Homeopathy: the Condition of the Regular Profession of Medicine

The 1790's - 1850's was the age of heroic medicine[3] but its regular practitioners had to face intense competition from others, notably the 'Indian (or herb) doctors', Thomsonians, botanics, eclectics and, by 1825, the

homeopaths.[4] The frontier conditions of colonial and early post-colonial America created demands for medical care which the regular heroic practitioners could not meet. This helped shape a market place which was segmented geographically and subtly reinforced the sectarian character of all the competing practitioners including the regulars. The basic social and geographical factors of the location of the concentrations of population, distances and rudimentary communication and transportation links meant that only small numbers of full-time professionally trained physicians could be supported financially. These full-time practitioners tended to be exclusively in urban areas, particularly those of the North East and Atlantic States. Generally then, medical practice was a part-time occupation, and most regular practitioners were products of the apprenticeship system.

This was especially true during the colonial period of United States history (i.e. about 1607-1789).[5]
As Rothstein notes,
"The practice of medicine as a full-time vocation was rare in the Americal colonies during the seventeenth and eighteenth centuries..... Most colonial physicians earned their livelihood as clergymen, teachers, government officials, or at other vocations and practiced medicine only part-time.....
The great majority of American practitioners at the time of

the American Revolution were products of the apprentice-ship system".(6)

Within this system of apprenticeship the quality of tutors, apprentices and training varied greatly such that the end product - physicians - varied considerably in their medical knowledge, practices and skills.

As urbanization increased, the ability of the domestic economy to support more full-time physicians increased, enabling medicine to become more of a vocation.

"As it did it became stratified, primarily by the amount and nature of the education of medical practitioners, which affected the kind of clientele they attracted".(7)

The scarcity of medical schools before the nineteenth century motivated the richer medical students to receive their medical education in Europe, notably Edinburgh, between 1750-1815.
"This elite of European-educated physicians constituted only a small minority of all practitioners".(8)

Even with this educational advantage -
"Well-educated physicians were unable to offer their patients therapies superior to those of the empirics".(9)

Constrained by these conditions the colonial population had a rather sceptical attitude towards the claims of the regulars which was demonstrated in the use they made of

self-medication, folk-medicine and recourse to the Indian doctors, Botanics, Thomsonians, Eclectics and Homeopaths as they historically emerged in American culture. This public scepticism was reflected in the dearth of effective legislation regarding the control of medical licensing by regular practitioners. Often, only honorific licensing measures were granted when physicians did attempt to obtain licensing regulations which would have limited the practice of medicine to regular, qualified, educated practitioners.(10)

The small number of regular medical graduates, medical colleges and the ineffective licensing legislation at the beginning of the nineteenth century helped produce an educationally varied group of practitioners. This led to variation in therapeutic practice, wealth and clients. Lacking occupational autonomy, monopoly and standardized education, regular practitioners sought some sort of control over practitioner education and recognition through the formation of exclusivist medical societies. These societies were formed at local, state and eventually national level with the creation of the American Medical Association (A.M.A.) in 1846/47. One unintended consequence of these local societies was to extend the individual factiousness between regular practitioners to the collective factiousness of the medical societies.(11)

Crucial to the establishing and collective identity of these exclusivist medical societies was a membership

policy which could clearly differentiate as to who was to be regarded as an acceptable, qualified, regular, 'scientific' practitioner of medicine, compared to those defined as...

"quacks, empirics or other undesirable competitors".(12)

However, whether a medical society had such a clear policy, or not, it could not affect who could practice medicine unless licensing powers were available to grant legitimacy to regular practitioners and were backed by practical, enforceable penalties against unlicensed practitioners. The problem was that:

"While legislatures were generally willing to grant licensing powers to medical societies, they were unwilling to enact laws which would have seriously deterred unlicensed practitioners".(13)

In point of fact...

"The most common differentiation between licensed and unlicensed practitioners was that only licensed practitioners had the right to sue for uncollected fees in court".(14)

But even at this point juries were often reluctant to convict unlicensed practitioners. Under these conditions of a sceptical public attitude towards regular practice as therapeutically effective, the lack of publicly enforceable licensing legislation and the internecine strife of the

regular practitioners and their institutions, it all tended to destabilize local, state and national attempts to achieve a unity of medical theory, practice and policy.(15) Or, at least an occupational unity which could withstand the pluralities of theory, practice and policy which actually existed amongst regular practitioners.

Under such conditions, the licensing boards were unable to be effective. Neither could they avoid the corrupting effect of their economic dependence upon the examining fee obtainable from the students applying to be licensed. To fail an applicant had the effect of undermining the financial basis of the board's activities and the remuneration of the examiners. So, despite the ineffectiveness of the boards, they continued because of the legitimacy conferred upon a practitioner who obtained a licence. The revenue "was an important source of income to the local societies"(16) and it provided the social prestige and status to its members which could attract more apprentices to their practice, who would later experience little trouble in passing the licence examination. Thus, the very structuration of the relationship between medical societies, boards and students applying for a medical licence was implicitly corrupting of the attempt to raise the standards of medical education.(17)

The only other ways that medical societies used to try and regulate the profession was that of agreed fee bills and

ethical codes. The former to try to prevent members of the society undercutting each others' fee-for-service; the latter to resolve the inherent conflicts over therapies in cases where additional physicians were consulted either at the patient's request or at the request of the physician who was originally called in to take the case. In these ways the medical societies sought to regulate the economic behaviour of competing practitioners and their professional relationships.

Such efforts were usually unsuccessful because of the "lack of sanctions to impose on deviant members, lack of control over non-members and impractical or unenforceable regulations..."(18)

By the mid-nineteenth century , medical schools had effectively replaced the apprenticeship system and had grown more numerous.(19) This was in direct relationship to the numerical increase of regular practitioners, and a profession which had become more influential and wealthier since the close of the previous century.

Because of the competitive commercial basis of medical schools they tended to be created whenever it was profitable for a group of practitioners to do so. This competition induced the schools to lower their standards in order to attract the number of students needed to make it not only a viable enterprise but also profitable to its lecturers.

However, during the first half of the nineteenth century educational standards were only as good as the state of medical knowledge, the quality and practicality of instruction and the quality of the medical profession. For the first four decades all these aspects were "consequently deficient in all aspects".(20)

The average course of instruction could last for two terms of four months duration, over two consecutive years and covered three broad areas of medical knowledge: basic sciences (i.e. chemistry, the theory and practice of anatomy, physiology, comparative and pathological anatomy); the theory and diagnosis of disease (i.e. rationalistic nosographies, pathology); and the treatment of disease (i.e. theory and practice of physic, materia medica, surgery, midwifery). Other courses such as medical jurisprudence and various specialisms like ophthalmology were added as medical knowledge increased and the impact of the Clinical-Hospital Cosmology began to be institutionalised by its European educated students upon their return from Paris, between the 1820's and 1850's.(21)

Because most states made the medical college diploma equivalent (in law) to the medical society licence the colleges were able to disregard the societies as to their status and activities. As communication and transportation facilities improved and urban populations increased, the

rural medical colleges declined in importance and the urban ones increased in importance, size and variety of medical subjects taught. In short, the medical colleges began to challenge the power of the medical societies within the profession. Conflict occurred because of their different interests.

"The medical societies, representing the interests of the rank-and-file of the profession, approved of the apprenticeship and licensing system....the societies wanted to limit the supply of new physicians to raise their members' earnings".(22)

But -

"the medical schools view them" [sic. apprenticeship and licensing system] "as hindrances to their growth....the schools wanted to enrol and graduate as many students as possible to increase their incomes".(23)

Thus the financial, career and status interests of each set of practitioners within the regular profession tended to be antagonistic, such that each blamed the other for the poor condition of the profession and the increase of alternative, non-regular practitioners.

The internal condition of the regular profession was certainly a factor in the decline of heroic medicine between 1790 and 1840. However, other causes contributed to this also, such as the frontier conditions of

America and the demand for medical practitioners. A demand the regulars were unable to meet, thus permitting other modes of practice to operate in the social space which was available. The anti-heroic position, which was common to all the non-regular practitioners, was spread far and wide with the production of mass circulation newspapers during the Jacksonian period of democracy (about 1828-40). This social and political philosophy emphasised the idea of the ordinary 'man-in-the-street', the 'common man'. Such a position was certainly espoused by Samuel Thomson (1769-1843) - the founder of Thomsonian botanical domestic medicine - whose motto was "To make every man his own physician".(24)

On this basis the Thomsonians opposed the licensing laws which gave a relative monopoly to the regulars and legislative sanctions against other practitioners. Other non-regulars opposed the legislative situation, for different reasons, but all were opposed to the advantageous legislation - hence legitimacy and status - the regular profession had managed to obtain from the various state legislatures. With the political and economic philosophy of Jacksonian democracy prevalent the non-regular, anti-heroic medical groups successfully campaigned against legislative monopoly of licensure by the regular profession.(25)

Successfully challenging the licensing legislation on the

issue as to

"whether the legislature had the right to give the regular profession a monopoly on medical care".(26)

The heterogeneous, anti-heroic medical movements were able to steadily remove licensure regulations which penalised and criminalised their own medical practices. By 1849, only New Jersey and Louisiana had such statutes on their books. One of the consequences of such repeal was to implicitly legalise the non-regular medical sects.(27) The regulars were quick to condemn the increased popularity of the irregulars. They located the origin of this increased public gullibility for 'quack' medicine and 'superstition' firmly within the camp of the irregulars and the defective mentality of 'the public'(28) in not recognising regular medicine as 'rational and scientific'. However,

"Despite physicians' complaints about the perverse ignorance of the public, it seems clear that people were deserting orthodox medicine for 'empiricism' not out of ignorance, but out of knowledge of regular practice and consequent dislike of it".(29)

Thus, the popular and effective anti-heroic, anti-monopolistic ideology of the Thomsonians, Eclectics, Botanics and Homeopaths was reflected especially between 1830-1850, in the declining legal position of the regular physicians

in regard to their quasi-monopoly of state licensing legislation, especially of the criminalising, punative kind.

By the mid-1840's many regular medical societies had concluded that licensing legislation was counter-productive. For example, in 1843, the Monroe County Medical Society of New York State had decided, after studying the information provided by other state medical societies regarding their legislation on medical education, that the following conclusions could be drawn:

" 'One thing is clear, viz. that Quackery and Patent Nostrums everywhere abound despite all law and the severest penalties. It is also equally evident that public opinion will not tolerate penal enactments prohibiting Empiricism. The committee therefore, unanimously come to the following conclusions:

First - That in the present state of the public mind all penal or prohibiting enactments are inexpedient.

Second - That it is most conformable to the spirit of our civil institutions to leave perfect liberty to all to practice medicine, being amenable only for injury done.

Third - That all legislation relative to the practice of Medicine and Surgery, as in all other Arts and Sciences, should only aim to encourage by affording such facilities

as may be necessary to its highest prosecution.

Fourth - That the important, if not the only remedy against Quackery, is Medical Reform, by which a higher standard of medical education shall be secured' ".[30]

The solution to the problem of defection from regular heroic medicine by the public and the rise of non-regular practitioners was seen by some regular practitioners to be with an improved medical education. This was the position taken by those who were later to form the American Medical Association (A.M.A.) in 1847.[31]

With this as basic background to their relationships we can take a closer look at the extremely hostile ideological warfare which broke out between the homeopaths and the regulars from about 1825 onwards. During those seventy-five years of homeopathy's development, reaching a numerical peak just after the 1850's and by the 1870's and 1880's

"it was the largest and most influential sect".[32]

However, it constantly needs to be borne in mind that despite this fact and because of it -

"The scientific claims of homeopathy have never been submitted to objective unbiased examination; rather, they were cast aside by orthodox practitioners as being too ridiculous to merit serious study".[33]

4.3 The Conflict Begins: 1826-1860

The earliest recorded homeopath in the United States of America was Hans Burch Gram, an American of Danish parentage. He was born in Boston but received his medical education in Copenhagen, where he was converted to homeopathy. He practiced it upon his return to New York in 1825. The first disciple of Gram was John F. Gray, sometime between 1825-28. There were no homeopathic medical 'schools' until one was organized by Drs. Henry Detwiller and Constantine Hering at Allentown, Pennsylvania in 1835.(34) In 1836 it received a charter under the name of the 'North American Academy of the Homeopathic Healing Art', but was known as the Allentown Academy. It was able to confer the degree of Doctor of Homeopathy but because instruction was in German its influence was limited. This accounts for the fact that it could not attract enough to be able to give instruction every year. Its last year of teaching was in 1841/42. It did however, publish the first American edition of Hahnemann's 'Organon' in 1836.(35)

In 1833 Dr. Constantine Hering had arrived in the United States and gradually become one of the intellectual and organizational leaders of homeopathy. It was Hering, remember, who had been converted to homeopathy whilst carrying out tests upon homeopathic practice and medicines which his mentor, Dr. Robbi, had originally intended to form the basis of its refutation. He failed and corroborated

it instead.

Homeopathic medical societies began to spread quickly as regular practitioners, - dissatisfied with heroic therapeutics of bleeding, purging, blistering and generally bludgeoning the patient, - began to convert to the gentler practice of homeopathy. This growth was not only due in part to the availability of English translations of the 'Organon' but also to the popular reaction to regular medicine promoted by the Thomsonians, Botanics and Eclectics. All had a common hostility to regular medicine but homeopathy appealed to the urban middle and upper classes rather than to the rural and urban lower-middle and working-class population. There were several reasons for this appeal to these particular social strata as they sought for an alternative to regular medicine.

"First, unlike its competitors, homeopathy was extremely fashionable among the European nobility and upper classes, whose tastes were often copied by affluent Americans. Second, the leaders of Thomsonianism and virtually all other movements opposing regular medicine were often uneducated laymen. Patients who could afford to pay for the best in medical care would hardly be attracted to any movement with this kind of leadership. Homeopathy was devised by a physician and the early American homeopaths were all well educated and cultured physicians".(36)

Third, its success in the cholera epidemic of 1848/49, which lasted well into 1854 in some places, gained it great publicity, respectability and numerical growth.(37)

Fourth, homeopathy seemed more systematic, experimental, empirical and 'scientific' than its heroic rival. 'Scientific' in the sense that it claimed to be based upon a natural law of cure which was supported by extensive experiment and the experience of many educated physicians.

Fifth, during the 1830's homeopathy was spread by immigrants as well as German and German-American graduates of the Allentown Academy. These largely German pioneers of homeopathy remained leaders of the profession for many decades. The German-American connection remained important to the founding and initial development of homeopathy in America. Meanwhile, Gram and his disciples began to convert established physicians in New York, successfully using his Masonic connections and presidency of the Medical and Philosophical Society of New York.(38)

These factors, together, constituted a serious threat to the social, medical and epistemic plausibility of regular heroic practice. Homeopathy, with the quality of its practitioners, its systemlike 'scientific' character, greater success and safety with its practices and its appeal to a high-class clientele, posed a greater threat to the continuity of the regular profession than Thomsonian,

Botanic, and Eclectic medicine ever did.

The attitude of homeopathic practitioners to regular medicine ranged from the catholic eclecticism proposed by John F. Gray as a basis for the common ground between them, to the doctrinal dogmatism of Hahnemannian purists like J.C. Peters.(39) However, the intellectual leaders of American homeopathy - men like Constantine Hering, John Gray and Henry Detwiller - tended to the more tolerant side of the dispute and were not averse to criticising some of Hahnemann's formulations. What they would not disagree over was the law of similars. This was the primary core of the homeopathic system, with a secondary core of disputable principles and theories - held with varying degrees of tenacity and certainty - such as the law of dilutions, simples, minimum dose, knowability of the organism, role of theory and experience in diagnosis, theory of chronic diseases, healing power of nature, dynamization and the relationship between therapeutics and basic medical sciences of physiology, pathology and surgery.

Despite these sources of theoretical and therapeutic agreement and disagreement amongst 'professional' homeopaths they enthusiastically evangelised members of regular medical societies. In point of fact.....

"This strong proselytizing effort distinguished homeopathy from all other medical sects and was at the root of the

peculiar hostility introduced into the relations between homeopathy and orthodox medicine".(40)

This was true until the latter part of the century when homeopathic medical colleges became the main source of its recruitment. However, this did not mean that converts from regular practice ceased but that the quantity from that source was reduced.

As homeopathy increased numerically, institutionally and in terms of clientele the attitudes of the regular practitioners hardened. What had begun with scepticism now turned to bitter hostility, with homeopaths being described as opportunists who were traitors to 'scientific' medicine and only concerned about pecuniary gain.(41)

The medical objections to homeopathy were two-fold. First, that homeopathic dilutions could not have any physiological effect at all. Second, that homeopathic 'cures' could be explained on the basis of the principle of the 'vis medicatrix naturae'. But as previously stated, the law of dilutions and size of the dose was of secondary character to most homeopaths. It was the law of similars which was the distinctive and uniting doctrine of homeopathy. Thus,

".....If homeopathy was to be disproven, regular physicians had to demonstrate that this so-called law was invalid. Because regular physicians used the same clinical methodology of administering a therapy and watching for the

effects on the patient as did the homeopaths, they were unable to verify or disprove it or any other scientific theory.....in such a situation neither system could attain scientific status".(42) This did not prevent either side from claiming such status though.

The core issue of the conflict was not over the materia medica as such(43) but over the therapeutic principle whereby it was employed in treatment. i.e. therapeutic ontology or methodology depending upon whether the 'law' of similars was interpreted on the basis of curantur or curentur respectively.(44) In terms of outcome for the patients health, homeopathy was the 'superior' system.

Some regular practitioners, like Jacob Bigelow in his 1854 work "Nature in Disease", recognised the sectarian attitudes of many homeopathic and regular physicians. Rather than responding to homeopathy in terms that minimized therapeutic differences and sought some ecumenical common ground, the regular profession's overwhelming response was to denounce it as a threat and attempt, by exclusion, legislation and ideological warfare, to exorcise the homeopaths in order to maintain its own sectarian, doctrinal purity.(45)

The existence of homeopaths within the ranks of regular medicine evoked deep social and psychological anxieties regarding the profession's collective identity. This sense

of threat was correctly felt at the level of routine regular practice and its rationalisation via medical philosophy and theory. The taken-for-granted practices and explanation of such practices were now questioned. The basic security system of regular practitioners involved modes of tension management which provided ontological security within the framework of a medical cosmology.

"Ontological security can be taken to depend upon the implicit faith actors have in the conventions..... routinely grounded in mutual knowledge employed such that interaction is 'unproblematic', or can be largely taken for granted".(46)

The homeopathic philosophy of medicine and its therapeutic practices radically questioned the routine practices of the regulars - (e.g. blistering, bleeding, polypharmacy, megadosing, nosology and posology). The hostile affective reactions were deeply rooted ones which cohered into a hostile response in regard to the collective defence of regular theory, practice, its medical colleges and societies.(47)

On the basis of the perceived threat from the homeopaths the regulars impugned their morality and mental health. Indeed, they regarded homeopathy as a form of moral and mental pollution which would corrupt anyone who became

involved with it. For example, Leonidas M. Lawson's (negative) review of Sir John Forbes' essay of 1846 "Homeopathy, Allopathy and 'Young Physic' " said:

"... its author [Hahnemann, the founder of homeopathy] little less than a lunatic... the system is obviously a lie in its conception, practice and assumptions, and truth will be impaired whenever it meets with such moral pestilence".(48)

This pollution - identifying and - avoiding ideology(49) is further demonstrated by an extract from the 1856 Transactions of the New Hampshire Medical Society which described homeopathic belief and practice in the following way:

" 'What should be the treatment of quackery? It should be that of abomination, loathing and hate. It should be considered the unclean thing - foul to the touch, wicked and treacherous to the soul - as a deadly miasm to every generous benevolent emotion - as the death of every upright principle..... how can we endure their bare betrayal and prostitution of our noble profession' ".(50)

This was fairly typical of the general reaction of regular practitioners to homeopathy during the 1840's to 1860's. Some of the regular professions ideological leaders reached far beyond the disease-polluting polemic of anti-homeopathic hostilities to those of the undermining of religion, morality and social order. In 1851, Worthington

Hooker compared homeopathy to a radical political heresy and 'orthodox medicine' as the analogue of the American Constitution.

" 'The radicalism which is so thoughtlessly encouraged by many of even the good and intelligent of the community to make its attacks upon us, is thus emboldened in its warfare against other interests, even against that precious of all interests, the best gift of God to man, the religion of the Bible. Such tendencies as this, surely, every good citizen, every lover of science, of good order, of morality, of religion, should resist in every form in which they may appear' ".(51)

These, and many like them, were fairly typical of the ideological counter-attack mounted by regular practitioners against the criticisms of Homeopaths during the 1840's to 1860's.(52) The intensity of the (attempted) exorcism of homeopaths from their ranks and the vilification of those outside their institutional ranks is reminiscent of the pollution or defilement avoiding behaviour which is described by Mary Douglas (1966) as

"the reaction which condemns any object or idea likely to confuse or contradict cherished classifications"(53)

and that can be extended to include medical tradition, philosophy, theory and practice. This proposal seems to integrate well with what has been previously stated about

Jewson's concept of medical cosmology. With previous suggestions about identity, conversion/alternation, commitments and the costs of change from one medical cosmology to another it does indicate the need for at least a preliminary descriptive theory of marginality, stigma and conversion which can tie in issues about medical knowledge and practice, commitments, identity, careers, power, legitimacy, deviance and the projects of occupational closure and professionalization.(54)

4.3.1 The American Institute of Homeopathy

With increasing numbers of converts to homeopathy in the 1840's the necessity for co-ordination of homeopathic medical education, certification and licensing began to be felt. Under the leadership of Constantine Hering and the New York Homeopathic Physician's Society, a convention was held in the New York Lyceum of Natural History, on the 10th. of April, 1844. Hering was elected its first president and they proposed to establish a society called 'The American Institute of Homeopathy' (A.I.H.). With this institute, the homeopaths were the first group of medical practitioners to organize themselves on a national institutional basis.(55) Its declared purpose was:

" ' 1. The reformation and augmentation of the materia medica.

2. The restraining of physicians from pretending to

> be competent to practice homeopathy who have not studied it in a careful and skilful manner' " (56)

So the A.I.H. was to act as "a clearing-house for pharmaceutical information among regular practitioners who had adopted homeopathic practice".(57) It was also to try and exercise control on the quality of homeopathic practice.

So the following year the A.I.H. resolved:

"Not to admit as a member of this Institute any person who has not pursued a regular course of medical studies according to the requirements of the existing medical institutions of our country, and, in addition thereto, sustained an examination before the censors of this Institute on the theory and practice of Homeopathy".(58)

This rather ingenious resolution not only had the intended consequence of maintaining a high quality of medical education but premised it upon the prior acquisition of a sound education in <u>regular</u> medicine at a recognized regular medical institution before even being allowed to be educated in homeopathic theory and practice. The unintended consequence was the implicit co-optation of the whole institutional system of regular medical education as part of the educational pre-requisite for entry into the fraternity of 'professional' homeopaths. The symbiotic (perhaps parasitical) relationship between

homeopathy and regular medicine was now formalized in terms of the resolution and focused the evangelisation of regular practitioners by homeopaths even more clearly. The fact of this resolution and the fact that homeopathy mainly recruited from regular medicine certainly indicated:

"The later charges of the American Medical Association that homeopaths were uneducated physicians were politically motivated and had no foundation in fact".(59)

The A.I.H. also advocated the founding of a homeopathic medical college. This was achieved in 1848 and the college was able to confer the degree of Doctor of Homeopathy, later extended to include the degree of Doctor of Medicine. Between 1848 and 1861, 399 students had graduated from the "Homeopathic Medical College of Pennsylvania".

In 1866 the rival 'Hahnemann Medical College of Philadelphia' was founded but three years later the two had been merged under the name of the "Hahnemannian Medical College". This was later extended, in 1885, to its contemporary title of the 'Hahnemannian College and Hospital of Philadelphia'.(60)

With the decline of public support for heroic practitioners, mounting internal criticism of the members of medical societies and colleges, the increasing criticism of heroic therapeutics by students of the Clinical-Hospital

Medicine of the Paris School, (especially students of Louis) and the increasing public support for homeopaths, the regular practitioners sought to protect their occupational interests by forming their own national professional organization. This they did under the rallying cry of improving medical education. Such a national reform organization would hopefully remedy the three elements of the deteriorating status of regular medicine:

"the public's increasing reluctance to patronize allopathy, the consequent inability of many of its practitioners to earn a living, and the conversion of many of them to homeopathy".(61)

So it was that the American Medical Association was formed in 1847. It was the product of repeated attempts at the reform of medical education since the 1820's(62) and the organizational response of the regulars to the formation of the A.I.H., which - as they interpreted it - promoted 'quackery' in the profession.

4.3.2 The American Medical Association

The reform of regular medical education had been proposed since at least 1825, initially by the Vermont State Medical Society. The Northampton (Massachusetts) Convention of medical colleges and societies had recommended, on June the 20th. 1827, the improvement of not only medical

education but pre-medical education.(63)

However, the colleges were just not prepared to accept reforms which would encourage students to go to colleges that did not accept and implement the proposed reforms. Thus the financial dependence of colleges upon student enrollment was the major disincentive to implement the needed reforms of medical education.

There were not only various calls by medical societies for the medical colleges to reform their educational standards but also calls for a national medical convention whereby the various societies and colleges could develop agreed standards of education. During the 1830's, such calls and recommendations were consistently ignored by the colleges.(64)

"It was naïve to expect the colleges to reform themselves. After all, many of them had been established as a result of professional jealousy, and each of them engaged in ruthless competition with other colleges. It would have taken a combination of Solomon-like wisdom and a direct threat to the survival of the schools to bring about the harmony necessary for a lasting reform of medical education".(65)

The continuing problems of the declining standards of medical education and the existence of 'irregular practitioners' within the regular profession prompted the

formation of the American Medical Association (A.M.A.) In fact,

"The problem of homeopathy was a major factor in the founding of the American Medical Association and was one reason for its survival and success".(66)

The leading light in this venture was Dr. Nathan Smith Davis (1817-1904) who from 1843-46 represented the Broome County Medical Society at the meetings of the Medical Society of the State of New York. It was at one of these sessions, in 1843, that he presented a resolution calling for the reform of medical education and the following year he began agitating for the formation of a national medical association as a means to accomplish that aim. This tactic of concentrating upon the reform of medical education was not unconnected to the fact that the State of New York had repealed the licencing legislation in regard to regular practitioners that same year. Other states soon began to follow.(67)

Davis spent 1845-47 campaigning to convince other regulars of the rightness of his proposal for a national medical association. A convention, inspired by Davis, was assembled on the 5th. of May 1846 at New York University. Of the 119 delegates who responded, 80 actually arrived at the convention. Its main business was to appoint various committees to report the following year on the

organization of a national medical association, the reform of medical education, proposed code of ethics, relationship of teaching and licensing, and prepare an address setting out the objects of the proposed association.(68)

In May 1847, the convention met in Philadelphia, this time with 250 representatives from 21 states; and the various committees, set up the previous year, provided the procedures and framework for what was to become the A.M.A., a title adopted at the convention's third meeting in 1848, at Baltimore.(69)

"Although ten states had no representatives and only about one third of the colleges sent delegates, it was a promising step in the direction of reform".(70)

The standing committee on educational reform, created at the 1846 convention, issued annual reports

"which were notable for their relentless castigation of American educational standards and reverential tone in describing European, and especially French standards".(71)

Such reports were well intentioned but it is not unfair to say that overall, in regard to actual improvement of medical education,

"the American Medical Association did nothing, in the first sixty years of its existence, for the improvement of medical education. The reason was that the medical

schools themselves viewed their education as perfectly adequate, in no way inferior to what it had formerly been. And the medical schools were well represented inside the American Medical Association".(72)

As an agency of reform the A.M.A.'s very composition of various sectional interests - rural versus urban practitioners, societies versus colleges, preceptors versus lecturers, clinical-hospital versus heroic-bedside advocates - was a recipe for self defeat. It was as divided as the profession at large and hence exhibited all its weaknesses.(73) Not only that but its inability to improve medical education significantly between 1847 and the emergence of the Flexner Report in 1910 was not just a reflection of competing, internal sectional interests, but also a result of the dilemma facing any voluntary medical association, local or national - how to resolve "the conflicting demands of purity and comprehensiveness".(74)

The repeal of licensing and the rise of well-educated homeopaths gave the issue greater urgency during the 1840's and 1850's.

"But facing the issue meant sacrificing either purity or harmony. Unprepared to make the choice, the profession in the end accomplished neither goal.

One suspects that the constant pleas for a purer profession that emerged from the annual meeting of the

voluntary societies served one purpose. In a sense they provided a substitute for taking any really effective action to raise professional standards. There was virtually nothing the societies could do between 1845 and 1860 but talk about the problem".(75)

Of greater interest but of equal historical importance, was the adoption of a code of medical ethics by the A.M.A., together with its clause regarding consultation with 'irregular' practitioners.

4.3.3 Problems of Demarcation: Ethics, Exclusion and Exorcism

The A.M.A.'s declared object was to provide a beneficial influence upon the medical profession by providing frequent opportunity for the expression of the professions views and better means

"for cultivating and advancing medical knowledge, for elevating the standard of medical education, for promoting the usefulness, honour and interests of the Medical Profession, for enlightening and directing public opinion in regard to duties, responsibilities and requirements of medical men, for exciting and encouraging emulation and concert of action in the profession, and for facilitating and fostering friendly intercourse between those who are engaged in it..." (76)

As well as these high ideals for the improvement of the

regular profession according to the demands of comprehensiveness, the demands of purity required not only a code of ethics, but also a means of exorcising homeopaths already within the ranks of the profession and barring those not already within from gaining entry.(77)

The main vehicle employed to deal with the homeopaths was the 1847 Code of Ethics. This was explicitly modelled upon the code of professional ethics and etiquette formulated by Thomas Percival in 1796 and published in 1803.(78) Several parts of the A.M.A. version dealt with the problem of relations with homeopaths (and other non-regular practitioners). Thus, it formulated the criteria of demarcation between regulars and homeopaths. One important part of this code was the consultation clause which proscribed the relations homeopaths and regulars could and could not have with each other.(79)

The problem inherent in the code in general and consultation clause in particular was that the terms of the conflict and debate between 'regular' and 'irregular' practitioners had changed since the late eighteenth and early nineteenth centuries. Prior to the rise of homeopathy in America (and Britain) the full-time practitioner with a formal medical training (and certificate to prove it) had tried to establish superiority over 'empirics' and the like on the basis of his university/college/medical school education. Now, with the emergence and

rise to dominance of clinical-hospital medicine, with its conservative/sceptical therapeutics, the existence of an equally well educated and certificated group of irregular practitioners - the homeopaths - the terms of the conflict had been changed. Yet, criteria only applicable to the earlier situation was still being used to subordinate and stigmatize the homeopaths. On the other hand the criteria of demarcation proposed by the ethical code and consultation clause would actually have to include most homeopaths as regular practitioners.(80)

It is worth quoting the first part of the consultation clause to demonstrate this fact.

"A regular medical education furnishes the only presumptive evidence of professional abilities and acquirements, and ought to be the only acknowledged right of an individual to the exercise and honours of his profession. Neverthless, as in consultation the good of the patient is the sole object in view, and this is often dependent on personal confidence, no intelligent regular practitioner, who has a license to practice from some medical board of known and acknowledged respectability, recognized by this association, and who is in good moral and professional standing, in the place in which he resides, should be fastidiously excluded from fellowship, or his aid refused in consultation, when it is requested by the patient. But no one can be considered as a regular practitioner or

a fit associate in consultation whose practice is based on an exclusive dogma, to the rejection of the accumulated experience of the profession, and of the aids actually furnished by anatomy,physiology, pathology and organic chemistry".(81)

Firstly, if these criteria were interpreted literally the the homeopaths were not irregulars (or 'quacks') because most of them had a regular medical education, did not practice homeopathy exclusively, nor reject the ancillary medical disciplines of 'anatomy, physiology and organic chemistry', or the 'accumulated experience of the profession'.

Secondly, it made no provision for the conversion of non-regulars to regular medicine since membership of the regular profession was defined in terms of who had educated you as a student: a regular or non-regular preceptor, or teacher.

"These provisions made it obvious that the intent of the resolutions was not to ostracize exponents of exclusive dogmas, but rather to make the penalties for any contact between a medical student and non-regular practitioners so severe as to make the persons rather than the dogmas of homeopathic physicians the object of the regulations".(82)

In addition, the 1847 Code stigmatized as 'quacks' all practitioners who claimed special healing ability,

patented instruments or medicines, used secret remedies or criticized other (i.e.regular) practitioners. On the latter of these criteria, most regulars would have to be labelled as 'quacks', but it does show how strongly they felt about their bid to create professional purity. It was in fact also a bid to stop, or at least inhibit, the acrimonious pamphlet wars of the 1830's and early 1840's.(83) Even taken as a whole, the Code did not succeed in drawing a line of moral, educational or professional demarcation between the educated homeopaths and educated regulars. What it did do was to formalize a specific ideological position through the medium of a national medical institution. However, it was a position which, in relation to the exorcism of homeopaths from their ranks, was not actually enforced with practical sanctions until the 1870's, when the A.M.A. insisted that all member societies purge themselves of homeopathic 'irregulars'. The adoption of the A.M.A.'s code of ethics by member societies

"did not signal the end of homeopathy, but rather the polarization of the medical profession"(84)

along even more ideologically sectarian lines.

Even so, the existence of homeopathy, alone of all the 'irregular' medical groups, forced the regulars to re-examine their concept of medical "orthodoxy". With the increasing collapse of heroic therapeutics - especially

bleeding, leeching, blistering and megadosing with mercurial compounds - and the rise of the conservative and sceptical therapeutics of clinical-hospital medicine during the 1840's-60's homeopathic claims to 'scientific legitimacy', on the basis of a natural law of cure, looked remarkably akin to regular medicine. If that was so, what claim to special (non-sectarian) status and legal privilege could be made by regulars?

The standard answer was that 'orthodox' medicine was not a sect because it had no medical creed.(85) But if that was so was not that another way of saying that regular medicine lacked scientific principle? It was no use saying they were 'scientific' because they relied only on observation and experiment; so did the homeopaths. By the very criteria of 'scientificity' expounded by the regulars the homeopaths were just as, perhaps even more, 'scientific'.

In combating the Thomsonians and Botanics the regulars had emphasised their superior education; against the homeopaths they mistakenly emphasised the same in 1847, but by 1852, their superiority was changed to that of free inquiry, and scepticism about medical dogmas like the 'similia similibus curantur'. Thus, the practice of sceptical therapeutics under the dominant clinical-hospital cosmology meant that,

"Until they could clearly establish their superior therapy, they could not expect special treatment".(86)

So, until the day arrived when the regulars had proven and established their therapeutics as superior; had reformed medical education and thereby improved the quality of regular practitioners by raising standards and reducing numbers of medical students being produced by the colleges; educated the public against the evils of 'quackery' and convinced them of the Truth and Goodness of regular medicine; some would continue to believe that every physician should keep a copy of the Code of Ethics by him, since...

"next to the Holy Scriptures, and the grace of God, it would serve most effectively to guard him from evil".(87)

Such a passionate attitude exemplified the reverence with which some regulars held the A.M.A. Code of Ethics. It was sacred to them. The sacred is the symbol of unity, harmony, truth, goodness, purity, order, the insider, the accepted, the orthodox and the healthy personality. Yet it is in constant symbiotic interaction with its shadow counterpart which symbolises disunity, disharmony, falsity, evil, uncleanness, disorder, the outsider, the marginal, the rejected, the unorthodox, the heretic, apostate and the corrupt personality. Such polemical texts are instantiations of those deeper, societal-wide, motivational

structures, affections, sentiments and traditions which generate symbolic universes composed of bi-polar, antagonistic forces or powers.(88) The homeopaths were rendered deviant, marginal and variously stigmatized as the regulars constructed the ideological groundwork for their professional occupational programme, by the marginalization of competitors and the monopolization of the capacity to dominate the division of medical labour. In the deviantizing of the homeopaths, with the associated marginality and stigmatized identity as an ongoing existential reality, the ideological conflict expressed in the polemical literature of the homeopaths and regulars - with all its passions, exaggerations and misinformation - is a prime source of marginalizing processes. The fact is that under the dominance of clinical-hospital sceptical therapeutics the regulars continued to exercise criteria of demarcation, exclusion and exorcism fairly successfully in order to retain their dominant occupational position and status. All this in the face of a well organized, well educated, profession of homeopaths who appeared as 'scientific' and at least as 'successful' in treating the ill as the regulars. The latter seemed to have no distinctive scientific basis to claim special treatment, honour, or legal advantages. One wonders how such a therapeutically uncertain system of medicine was able to continue stigmatizing and marginalizing the homeopaths when the definitions of quackery could no longer be applied to them in any

consistent and coherent fashion?

As a partial answer to this question a specific selection from the anti-homeopathic polemical lierature will be made - that by Oliver Wendell Holmes (1809-94) originally presented as two lectures in 1842.(89)

4.3.4 Holmes Against the Homeopaths: Sustaining the Conflict

Although several anti-homeopathic publications had been written before Holmes put pen to paper, his was -

"the first serious counter-attack by orthodox medicine, the author's wit and style compensating somewhat for his lack of depth and failure to comprehend the underlying scientific and philosophical issues".(90)

Holmes had received his medical education at the Boston Medical School (1831-33) with additional tuition at the Harvard Medical School. Here he came under the considerable influence of Jacob Bigelow (1786-1879), botanist and physician, and at this time the professor of materia medica (1815-55) at Harvard Medical School. It was Bigelow who first effectively wrote against the megadosing, poly-pharmacy and excessive blood-letting prevalent in American regular practice. He argued in his work of 1835, "Discourse on Self-limited Diseases" that many illnesses had a natural course of morbidity to progress through. If that course and the natural recuperative powers of the body were not

interfered with by the physician then the disorders would disappear more rapidly than if the physician intervened with excessive therapies. In this discourse -

"Bigelow had listed the self-limited diseases and assumed the remainder susceptible to art".(91)

Holmes later regarded this specific work of Bigelow as exerting

"more influence upon medical practice in America than any work that had ever been published in this country".(92)

Whatever the truth of Holmes' evaluation of Bigelow's influence upon other American physicians it certainly influenced Holmes himself. Bigelow's therapeutic conservatism, in a limited number of specific cases of morbidity, provided no necessary limitation upon the extension of an aspect of Holmes' developing medical philosophy.when the latter spent the next three years (1833-35) in intensive study with the Paris School of Clinical Medicine. Here in the 'medical Mecca' of Europe he was deeply influenced by the ablest teachers of clinical medicine. Particularly important in his medical education and development was the pathologist Pierre Charles Alexander Louis, the 'father of medical statistics' in clinical research.

From his clinical education in Paris he came to value three principles:

" 'not to take authority when I can have facts; not to guess when I can know; not to think a man must take physic when he is sick' ".(93)

This certainly reinforced what he had learned from Bigelow about not drugging patients for its own sake and took it somewhat further so that heroic therapeutics,

"were effectively discouraged by the hours spent with Louis".(94)

Holmes summed up what he had learned in Paris as a philosophy of medicine which gave him,

" 'The love of truth, the habit of passionless listening to the teaching of nature, the most careful and searching methods in observation' ".(95)

He returned to the States in 1835 and qualified as M.D. the following year at Harvard Medical School. Upon which he promptly joined the Massachusetts Medical Society and pursued his medical career. He began it by winning the Boylston prize in 1836 for an essay entitled "Facts and Traditions respecting the existence of Indigenous Intermittent Fever in New England"

Although he began his medical practice in Boston from No. 2. Central Court (his old boarding house) it was as a medical writer and teacher of anatomy that he actually made his mark in the regular profession.(96) Appointed

as a visiting physician at the Boston Dispensary - a charitable hospital - he was able to practice the approach to clinical diagnosis he had been trained for in Paris and upon the same kinds of clinical materials too - the urban poor.

"Although patients were not many, he was occupied with giving reports at the 'Boston Society for Medical Improvement' and tending cases at the Boston Dispensary".(97)

His friendship with Bigelow was re-established in 1838 when together with two other physicians they formed the Tremont Medical School in order to provide experience in dissection and clinical studies to supplement lectures at Harvard Medical School. In the same year he published two essays, 'The Nature and Treatment of Neuralgia' and 'How far the external means of exploring the condition of the internal organs is to be considered useful and important in medical practice'. Both of these were good examples of his Parisian Clinical philosophy regarding accurate diagnosis and the usefulness of physical examination.

In July of 1838 he was appointed Professor of Anatomy and Physiology, at Dartmouth College, Hanover, New Hampshire. Here he lectured for fourteen weeks each autumn and looked after the anatomical museum. In 1840 he resigned his

professorship and married Amelia Jackson on June the 15th. of that year. It was during this time (1840-46) that he supported himself through patients' fees, consultations and some lecturing, of which two on medical quackery are important to this study.

Having made his intellectual mark upon the medical profession by clearly displaying his commitments to the philosophy of clinical-hospital medicine and by implication, therapeutic scepticism, he had also tacitly declared himself against the heroic practices of over-drugging, bleeding, leeching and other abuses of the materia medica.

Having so declared his intellectual commitments to and identification with the increasingly intellectually dominant clinical-hospital cosmology, he now also declared his ideological commitment to and identification with the 'anti-quack' (i.e. anti-homeopathic) stance of the regular profession. By this means he was able to appeal to all the profession, be they committed to heroic-bedside or clinical-hospital medical theory and practice. This ideological declaration of professional solidarity may have been a factor in the length of time it took for some heroic practitioners to respond to his essay on 'The Contagiousness of Puerperal Fever', of 1843. The response came from

"Two leading professors and practitioners of obstetrics

in Philadelphia, H.L. Hodge and C.D. Meigs [qq.v.], attempted, respectively nine and eleven years after Holmes' pamphlet appeared, to oppose its teaching in a pamphlet of their own".(98)

The two lectures referred to above were presented to the 'Boston Society for the Diffusion of Useful Knowledge', in 1842.(99) He entitled them "Homeopathy and its Kindred Delusions".(100) It was presented in the grand, witty but satirical style of the man of letters. It was this, rather than his profundity of thought, which characterised his polemic against homeopathy. His aim was to show, through particular examples, that irregular and 'quack' medicine -

"All display in superfluous abundance the boundless credulity and excitability of mankind upon subjects connected with medicine".(101)

In his first lecture he discussed and satirized four defunct medical beliefs and therapies, namely the Royal Cure of the King's evil (or scrofula); weapon ointment and sympathetic powder; the tar water mania of Bishop Berkley and the history of the metallic tractors, or Perkinism.(102) He then turned his attention to homeopathy and Hahnemann and declared that:

"I shall treat it, not by ridicule, but by argument; perhaps with great freedom, but with a good temper and

in peaceable language; with very little hope of reclaiming converts, with no desire of making enemies, but with a firm belief that its pretensions and assertions cannot stand before a single hour of calm investigation".(103)

Yet in the process of his arguments he glossed the origin and history of homeopathy to claim that it was the homeopaths who had originally wanted to do battle with the regulars by coining a sectarian name for them (i.e. Allopathists) and rejecting, or trying to show as insignificant, all previously existing knowledge.(104) The previous evidence on the origin of homeopathy and its conflict with the regular physician, whether in Germany or the United States of America, do not support his interpretation of their relationship; nor was it true that all existing medical knowledge was rejected, or minimised, by them. On the basis of their therapeutic principles the homeopaths were against heroic practices which they held as being based upon the 'contrari contrarii curentur' principle, this being inherently antagonistic to the 'similia' principle and the natural healing powers of the body as then understood.

He claimed to be undertaking -

"a sober examination of its principles, its facts, and some points of its history".....(105)

and that

"Not one statement shall be made which cannot be supported by unimpeachable reference".(106)

He certainly did examine its principles, facts and certain of its historical developments but only to ridicule them, a standard tactic of a stigmatizing strategy consistently reproduced by the regulars the rest of the century and beyond. His unimpeachable references, such as Louis, Andral and others(107) were not beyond criticism regarding their 'evidence' against homeopathy.

Holmes actually recognized the 'Catch-22' type-situation of any anti-homeopathic evidence he might present, when he said in his opening remarks that he had not carried out any experimental tests upon homeopathic remedies, nor did he need to because -

"I could by no possibility perform any experiments the result of which could not be easily explained away so as to be of no conclusive significance".(108)

These kinds of evidential claims and counter-claims, supposedly given authority by 'scientific' experiments, was typical of the ideological conflict between homeopathy and the regulars at this time. Under such circumstances it is difficult, if not impossible, to sort out historical 'fact' from historical 'fiction'. So, rather than try to,

we will simply accept it as a socio-historical fact that such debate constituted part of the stigma-contests which occurred in both the professional and public forums of debate. Such contests and their outcomes were expressions of the relative resources of power (social, political, ideological, institutional, legislative, intellectual) the conflicting groups could draw upon.(109)

Broadly speaking the organization of his material divides into about six sections as follows.

1. P.39-41 General remarks, his intentions, aims and admissions.

2. P.41-51 Presentation of Hahnemann's fundamental doctrines of similia, dilutions and theory of chronic disease; plus some ancillary doctrines on the minimizing of natural cure by homeopaths, simple single medicines, activation of inert substances by homeopathic preparations, dependence upon symptomology and unnecessary detail in case-history taking. Questioning of contemporary homeopathists adherence to Hahnemann's doctrines. How they invoke the story of the ridicule and persecution of Galileo, Harvey and Copernicus to support their refusal to accept justifiable criticism of their theories and practices.

3. P.51-70 Critical examination of homeopathic doctrines. He spends most time (nearly 5 pages) on criticising

the theory of dilutions and potency. But he mis-calculated the quantity of units of medium (i.e. milk sugar) needed to attain the various dilutions.(110) He argues (P.52) that the similia is of limited application and neither is it explained by analogy with vaccination, since the latters'morbid material increases itself, whereas similia preparations are diluted even more in the body (P.54-55).

4. P.70-84 Does homeopathy actually work? What are the sources of the evidence needed to answer such a question? - the public, homeopaths themselves and trials by impartial physicians. He concludes that the public are not competent to judge; homeopathic statistics on comparative morbidity prove nothing because of the variation from hospital to hospital; public trials(P.77-82) came out against the truth of homeopathic claims for their drugs.

5. P.84-99 Miscellaneous remarks on homeopathic literature, its failing condition in Paris and England (P.84-97). False accusation of bigotry against the (regular) medical profession (P.97). Time and number of adherents will show whether it is true or not. Homeopathy fails both tests (P.98). Reasons for the future demise of homeopathy (P.98-99).

6.P.100-102 Final Remarks. (The rhetoric of stigmatization and worth quoting in full).

His lecture/essay, but particularly his concluding remarks, was memorable more for its wit, eloquence and style than its claimed 'fair' treatment of homeopathy as a perceived medical delusion. Indeed, it was probably his style and the easy Latinity of his public speaking and writing which gained it a reputation as a classic refutation of homeopathy during the latter part of his life.(111)

In his final remarks upon homeopathy Holmes said that -

"If, as must be admitted, no one of Hahnemann's doctrines is received with tolerable unanimity among his disciples, except the central axiom, 'Similia similibus curantur'; if this axiom itself relies mainly for its support upon the folly and trickery of Hahnemann, what can we think of those who announce themselves ready to relinquish all the accumulated treasures of our art, to trifle with life upon the strength of these fantastic theories? What shall we think of professed practitioners of medicine, if, in the words of Jahn, 'from ignorance, for their personal convenience, or through charlatanism, they treat their patients one day Homeopathically and the next Allopathically'; if they parade their pretended new science before the unguarded portion of the community; if they suffer their names to be coupled with it wherever it may gain a credulous patient; and deny all responsibility for its character, refuse all argument for its doctrines, allege no palliation for the ignorance and deception

interwoven with every thread of its flimsy tissue, when they are questioned by those competent to judge and entitled to an answer?

Such is the pretended science of Homeopathy to which you are asked to trust your lives and the lives of those dearest to you. A mingled mass of perverse ingenuity, of tinsel erudition, of imbecile credulity and of artful misrepresentation, too often mingled in practice, if we may trust the authority of its founder, with heartless and shameless imposition. Because it is suffered so often to appeal unanswered to the public, because it has its journals, its patrons, its apostles, some are weak enough to suppose it can escape the inevitable doom of utter disgrace and oblivion. Not many years can pass away before the same curiosity excited by one of Perkins's Tractors will be awakened at the sight of one of the Infinitesimal Globules. If it should claim a longer existence, it can only be by falling into the hands of the sordid wretches who wring their bread from the cold grasp of disease and death in the hovels of ignorant poverty.

As one humble member of a profession which for more than two thousand years has devoted itself to the pursuit of the best earthly interests of mankind, always assailed and insulted from without by such as are ignorant of its infinite perplexities and labours, always striving in unequal contest with the hundred armed giant who walks in

the noonday, and sleeps not in the midnight, yet still toiling, not merely for itself and the present moment, but for the race and the future, I have lifted up my voice against this lifeless delusion, rolling its shapeless bulk into the path of a noble science it is too weak to strike, or to injure".(112)

4.3.5 Some Observations

As a standard piece of anti-homeopathic rhetoric it bears specific characteristics. Nowhere does it admit of the weaknesses of its own theory and practice, be it heroic therapeutic certainty or clinical therapeutic scepticism. It is only nearly twenty years later (1861) that Holmes is willing to concede a lesson learnt from homeopathy to the effect that,

"it has taught us a lesson of the healing faculty of Nature which was needed, and for which many of us have made proper acknowledgment".(113)

He was later to admit further that homeopathy had helped break up various heroic practices. That is to say -

"the dealers in this preposterous system of pseudo-therapeutics have co-operated with the wiser class of practitioners in breaking up the system of over-dosing and over-drugging which has been one of the standing reproaches of medical practice".(114)

But even so, there is obvious misinterpretation of the historical facts in order to constantly present the regular profession as the repository of true and good medicine, as well as the possessor of a virtual monopoly of true, good and wise practitioners.

This process of stigmatization ranges from the purity seeking, socio-moral boundary defining functions of the 1847, A.M.A. Code of Ethics, to the use of invisible reference groups of the present or the past (e.g. quacks, mountebanks, knaves, Perkinists and so on) who are regarded as being of the same deviant type as homeopaths.(115) These are the standard 'ad hominem' denunciations of Hahnemann and his adherents(116) and the impugning of motives(117) which was disliked by both sides.(118) By such means the A.M.A. and regular practitioners, spurred on by a specific anti-quack ideology which functioned to systematically exclude counter-arguments as valid, sought to make professional purity an internal reality. Thus they demonized(119) Hahnemann, his ideas and his followers. Once cast in such a stigmatized role the homeopaths had to be exorcised. But this proved more difficult than it seemed at first. From this flowed in later years the persecutions, denial of access to civic hospitals, university medical faculties, armed forces or other normal means of career pursuit within the (regular) medical profession.(120)

However, the homeopaths did not respond to Holmes' criticisms passively. Within the same year doctors A.H. Okie and Charles Neidhard of Philadelphia had responded.[121] Neidhard's response is the most concise and specific in regard to Holmes' criticisms.

4.3.6 A Response to Holmes from Charles Neidhard, 1842

Neidhard's (1809-95) reply to Holmes is a typical example of the kind of arguments brought forward by homeopaths to defend their doctrines of similia, dilutions and simple, single remedies.

He follows Holmes' organization of his material and rebutts him point by point. But broadly speaking there are eight parts to his answer to Holmes, as follows.

1. P. 3-7 Opening Remarks.

2. P. 7-11 Detailed examination of Holmes' arguments on Hahnemann's fundamental doctrines.

3. P.12-18 Defence of Hahnemann's methods of obtaining evidence about the effect of drugs on healthy persons. The experimental trials of Andral and others which claim to refute homeopathic provings and their efficacy are examined and shown to be unsoundly based (P.14-16).

4. P.18-19 Some proof for the truth of the 'similia' from recent microscopical work of Dr. Kaltenbrumen on the anatomy

and physiology of inflammation.

5. P.19-28 Veracity of the sources of facts about homeopathy - the public, homeopaths and non-partisan physicians.

6. P.28-31 Various inaccuracies about state of homeopathy are pointed out. Hydropathy is no threat to homeopaths, who recommend it in appropriate cases.

7. P.31 Holmes' objections stem from lack of knowledge about homeopathy.

8. P.32-36 An appended letter from a Mr. Croserio 'proving' that homeopathy is advancing well in Europe.

The point by point rejoinders to Holmes notwithstanding, Neidhard's basic objections are summed up in his own words when he says that -

"All those who have honestly and thoroughly studied the science, and made it the subject of practical experience, have become converts. All merely theoretical reasoners of course, not. To this class belongs the author of the present lecture .....

It is to be regretted, that the author thus permitting himself to be deterred by others, did not study the homeopathic method, and institute a full course of experiments; his conclusions, we are sure, provided he had entered upon them with an honest purpose and in the right spirit,

would then have been very different.....

The main points, on which Dr. Holmes' whole discussion ought to have rested, he has therefore set aside, and he has consequently deprived himself of the most powerful means to crush (if that was his object as we must suspect) the new doctrine".(122)

The claimed refutations of homeopathy by the 'experiments' of Andral, Bailly, Louis Fleure and others was rejected by Neidhard, on various grounds, not least

"the imbecility and total want of justice manifested by these high placed judges".(123)

In fact, in the case of Bailly's claimed experiments, Neidhard and a Dr. Simon were the homeopaths in question who treated the patients Dr. Bailly gave them. Neidhard claimed they were given patients with incurable conditions from the Hôtel Dieu and accorded few facilities whereby to treat them. Dr. Bailly, Neidhard claimed, also 'lost' his private register which recorded

"that the condition of several of the incurable patients was ameliorated by our treatment, and that the few curable ones were actually cured".(124)

Such 'stories' as these, repeated throughout the homeopathic and regular polemical literature, were produced by their mutual responses which was co-ordinated by

socially tacit, ideological traditions. Neither side was willing to concede the content of the others' stories in regard to the weaknesses or non-validity of their own practices.(125)

4.3.7 Some Functions of Stigmatization

The function of such stories was to confirm already existing attitudes and conclusions about each other. Each claimed that empirical experiment demonstrated the truth of their own claims about the other side - that they were credulous and obstinate. Credulous to believe all that their own group said, and obstinate in the face of evidence to the contrary. Of course, small concessions were made from time to time. For example, Holmes was later to concede that homeopaths had taught the regulars a lesson about the healing power of Nature.(126) But even that was a double-edged compliment in so far as the notion of the healing power of nature was often an argument brought forward to explain away the apparent 'success' of homeopathic remedies.(127)

This was in fact one of the conclusions to which therapeutic scepticism led those, like Holmes, committed to the Clinical-Hospital Cosmology.(128)

Through the stigmatization of homeopaths, the regulars maintained their relative dominance in the medical market place until such time as they could reform medical

education and gain legislative advantages from the polity to enable occupational monopoly to be fully effected.(129) Their specific stigmatization was ideologically integrated with a wider anti-quack polemic such that the homeopaths were categorized with patent medicine dealers, sellers of secret nostrums and the like.(130) In Holmes case it was the medical follies of the Royal touch, tar water, weapon ointment and Perkinism.(131)

Such a process also constantly impugned the motives of homeopaths. Those who claimed to be converts to homeopathy were assumed by regulars to have become so for financial reasons only, or because of their incompetence at regular medicine. Honest conversion was not accepted as a true explanation of their new beliefs and practices until the 1890's. This is not to say that, empirically, some did 'convert' for less than honest reasons. However, it is to point out that as far as the regulars were concerned, homeopathy was an incredulous system and anyone who practiced it must be either insane, unintelligent, wicked or all three.(132)

Under the impact of Jacksonian populist democracy, the regular (heroic) medical societies had gradually lost their legal privileges regarding licensing. It was further compromised by the filling of this occupational space with the certification which the medical schools and colleges could provide. With the demise of many heroic practices

by the 1860's, the emerging clinically trained, therapeutically sceptical, intellectual elite of the profession recognised that the rise of homeopathy was a severe threat to their plausibility as the emerging dominant bearers of the Good and the True in medical theory and practice. Since few regular medical societies had legislative advantages over the homeopaths the regulars had to demonstrate they had distinctive goods and services. Ideological conflict in terms of the stigmatization of homeopaths served as a means to this end, in a negative sense, i.e. it was to show that the homeopaths had not only no distinctive goods and services, but that the ones they did claim to have were spurious and not founded upon recognized 'scientific' principles. The recognition criteria of course were defined by the regular profession. However much the regulars were divided over medical theory and therapeutic practice they were largely united in their opposition to the homeopathic threat.

The purpose of the A.M.A. was both the reform of medical education in order to overcome the reproaches brought upon the profession by the critics of heroic medicine, and the protection of the (sectional) interests of that same profession. These twin aims were originally in conflict. Thus for the next sixty years the latter purpose was largely pursued in the face of the constant failure to reform the medical colleges. Such failure largely being due to

the undermining of suggested reforms by the colleges themselves. The homeopathic 'threat' created a defensive mentality amongst the regular practitioners, such that in 1883, a New York physician, in the battle to abolish the A.M.A. consultation clause, could say that the national code of ethics had

"created a multitude of star chambers all over the land".(133)

However, in the same year a professor of municipal law argued, in relation to the consultation clause, that:

"the rule in question is the action of an organized body of men. It is the act of combination. The men thus combining are considered by many, and consider themselves, the most competent practitioners, the only fully qualified practitioners of the State. By adopting this rule they combine to deprive the community of the best advice to be had in the cases of sickness. Such a consideration is against the common law and the provisions of the statute as well.....
It is a conspiracy against the public health".(134)

So, at least in New York State, the action of the state medical societies in complying with the A.M.A. consultation clause was probably illegal for over thirty years. Thus another function of stigmatization was to obscure the perception of the legality or illegality of specific

actions in the pursuit of the protection and extension of sectional and occupational interests. In the face of the loss of legislative advantages the regular profession had little choice but to pursue the neutraliztion - and hopefully the elimination - of the homeopaths by means of ideological warfare through public lectures, pamphlets, tracts and journal articles. This, of course, brought forth a similar, but not as intensely hostile a reaction from the homeopaths. They were the recipients of this hostility for at least thirty-six years when a move to reform the A.M.A. Code of Ethics and repeal the consultation clause by some members of the New York State Medical Society took place.

4.3.8 A Preliminary Conclusion

As far as the anti-quack, anti-homeopathic ideology of most of the regular profession was concerned and as specifically formalized by the 1847 A.M.A. ethical code and its later educational reform committees[135] the homeopaths were destroying the profession from within by means of their 'heresy'. They were men pretending to be 'sane' in presenting their doctrines, theories and practices. If they claimed to be 'rational' or 'scientific' then they were not only heretical but 'evil' too. Thus homeopathy became part of the medical 'demonology' of quackery and the anti-quack ideology operated at many levels simultaneously - individual, institutional,

occupational and political. First, to hinder or prevent the conversion of regular practitioners and students of regular medicine to the homeopathic medical cosmology. This we may term its pastoral counselling function, to de-fuse potential situations of anxiety and doubt regarding the truth of whatever principles that regular theory and practice were based upon, by 'demonstrating' the 'falsity' of homeopathic claims. Second, whether formalized into something like the A.M.A. ethical code, or not, it attempted to restrict the physical and cognitive contacts regular practitioners could have with homeopaths and homeopathy, since they were obviously a threat - actual or imagined - to the continuing plausibility of the legitimation of theories and practices of regular medicine. Third, by identifying a common enemy of a medical profession wracked by internal conflict [between medical societies and colleges, rural and urban practitioners, heroic-bedside and clinical-hospital medical philosophy, therapeutic certainties and therapeutic scepticism] it was able, superficially, to unite the profession at large in the protection of their occupational interests through the gaining of legislative advantages in order to accomplish occupational closure against 'irregulars' and thereby control the division of medical labour and the medical market place. The creation and maintenance of a medical 'heresy' to which the possible disintegration of (regular) medical 'science' could be

attributed, if it was permitted to develop, was both the medium and the outcome of a process of monopolization whose sociological 'underside' was manifested through the process of marginalization and hence subordination to a numerically more powerful group which was prepared to wage long-term ideological conflict to secure its continuity and professional legitimacy by means of advantageous legislation and manipulation of the rhetoric of 'science'.

4.4 Conflict and Co-operation: 1870-1890

The improved status of homeopaths, socially and professionally, on the basis of their educational qualifications and appeal to the middle and upper classes in urban centres, especially on the East Coast, enabled a certain amount of co-operation to take place between them and regulars. They both faced a threat from the rise of new medical sects; namely osteopathy, chiropractic and Christian Science healers. The already well tried anti-quack polemics of the regulars and the anti-heroic polemics of the homeopaths were quickly used, in modified form, to deal with the new competitors in the healing arts. Medical examination boards in the basic medical sciences of anatomy, pathology, surgery and clinical medicine were created. They were filled by homeopathic, eclectic and regular physicians, either on separate or combined boards. Combined boards were found to be the most effective means of acting against the new 'quackery'.(136)

Thus they united behind

"legislation which would guarantee their own existence; but would eliminate the minor sects".(137)

Of course some of the more conservative regulars who could remember the bitter conflicts of the 1840's-60's resisted this move, but

"most of the orthodox physicians, then were willing to co-operate with homeopaths in order to eliminate quacks and pretenders, a category which not too long before had included homeopaths".(138)

However, at the same time as a certain amount of co-operation was occurring between homeopaths and regulars, the regulars were also pressing to improve state medical licensure laws in their favour. These had to be toned down in order to maintain homeopathic co-operation against the new marginal practitioners. The general result of their co-operation on the state examining boards was to push the new healing cults further west. The homeopaths were also allowed to gain access to institutions they had previously been denied entry to - the Army Medical Corps, Navy Medical Corps and municipal hospitals. However, the public confession of their homeopathic sins was sometimes required for such access to be given. For example, in 1888 the Massachusetts Medical Society decided that homeopathic graduates could be admitted to professional

fellowship on condition that the candidate:

"repudiate homeopathy, publicly renounce its every tenet and practically assert that he had been living in sin".(139)

Compliance by a few homeopaths with this ritual purification behaviour led to increased strife within the homeopathic ranks who were already suffering from internal divisions over the doctrine of dilutions, stemming from the 1860's.

4.4.1 Pollution and Purity Within Homeopathy

This internal split had expressed itself doctrinally over whether Hahnemann taught that homeopathy was characterized by high or low dilutions in its remedies. The Hahnemannians, or purists, advocated high-dilutions. They venerated Hahnemann as a medical Messiah and accepted his writings as virtual revelation. The eclectic Homeopaths advocated not just low dilutions but the whole range of dilutions, including those given by the regulars. A further issue between them was over whether the theory of dilutions was a distinctive characteristic of homeopathy or not. They both agreed that the similia principle was distinctive of homeopathy but disagreed over all the other doctrines - dilutions, potency, single remedy, minimum dose and so on.(140)

Part of the reason for this internal split was rooted in

the social and psychological fact that sometimes conversion from one medical cosmology (regular medicine) to another (homeopathy) is not always complete. Some will retain aspects of their previous practices, by substituting them for homeopathic ones their regular physician friends found ridiculous (e.g. infinitesimals). By 1880 the internal strife became so intense that a formal separation of purists and eclectics was proposed at the Milwaukee meeting of the A.I.H. The purists left the institute and formed the International Hahnemannian Association (I.H.A.). Unfortunately they were a minority of professional homeopaths and tended to be both narrowly dogmatic and literalistic over Hahnemann's teaching. Lacking critical historical insight into them as a body of writings developed over a period of thirty two years they conceptually fixed them into a rigid confessional system.(141)

4.4.2 A.M.A. Consultation Clause Under Pressure: Defence of the Sacred

Notwithstanding such internal conflict amongst themselves, the homeopaths' esteem increased in the eyes of the public as skilful practitioners of the art of medicine and in the eyes of not a few regulars - mostly those from the North Eastern States - who were able to compete financially and intellectually with them. Throughout the 1870's and 1880's the therapeutic views of the regulars were decidedly influenced by those of the homeopaths. For example, one

physician wrote:

" 'Legitimate medicine owes not a little to the homeopathists for stimulus given to investigation into the so-called physiological action of drugs' ".[142]

It was common knowledge that the consultation clause of 1847 was going by default and some began to agitate for the abolition of it from the A.M.A. Code of Ethics. This led the younger physicians of the New York State Medical Society to propose, in 1882, that the A.M.A. consultation clause be amended so that consultation between homeopaths and regulars could take place in emergency situations and so yield to the demands of humanity.[143] Prior to this the clause was interpreted to mean that patients could be left to die if the homeopathic practitioner was not first made to relinquish the power of medical decision and responsibility for the case and removed from the situation altogether.

The supporters of the amended code were generally a younger generation of physicians who saw the reasons for the consultation clause of 1847 as no longer applicable in its present form. They also wanted a strict licensing law but the state legislature would not adopt such a law unless it had homeopathic support and treated the homeopaths to equal advantages. Homeopathic support for such legislation was to be obtained only for a price - the

abolition of the consultation clause from the Medical society's regulations. The majority were prepared to do that and by a vote of 52 to 18 they adopted the revised code of ethics in 1882.

The same year the A.M.A. polarized the profession when it passed a resolution strongly condemning the New York State Medical Society, and in 1883 helped establish the opponents of the new code as a competing organization, the New York State Medical Association, which continued until 1906. However, the response of the 1882 A.M.A. convention in the mid-west, which expelled the New York State Medical Society from fellowship, was more a reflection of the -

"differences between physicians of the east and those of the other sections of the country".(144)

In the east the regulars and homeopaths were intellectual and educational equals since conditions of licensure were relatively better. This situation was not universal to the rest of the United States of America and since the 1882 convention was held in the mid-west rural states, they were naturally over-represented and

"a number of physicians who might have defended the bastions of the New Yorkers were notably missing from the 1882 meeting".(145)

The following year the A.M.A. made any compromise over the old code impossible and intensified the polarization by asking every delegate at its Cleveland convention to sign a pledge of commitment to it and rejected the proposal to form a committee to specifically examine the old code and revise it in line with contemporary demands.

This mutual hostility simmered on for the next few years but in 1885 it threatened to undermine the possibility of the medical profession hosting the Ninth International Medical Congress. Many elite physicians in New York State and beyond, had been alienated by the conservatism and hostility of the A.M.A. leadership over the new code. The profession would be virtually bereft of medical men of scientific eminence. Henry I. Bowditch was such a physician, barred from attending the Congress because of his advocacy of the new code and his consultations with known homeopaths. When the supporters of the old code conceded to the necessity to have medical men of eminence at the Congress and re-invited Bowditch, he refused to attend at such short notice. The whole situation made Bowditch an embittered man.(146)

4.4.3 Remarks on the Pursuit of Purity

The pursuit of professional purity and the defence of that which is sacred, illustrated by the previous examples of the conflicts between high and low dilutionists within

homeopathy; and those between reformers of, and adherents to, the A.M.A. 1847 consultation clause within the regular profession, enables specific political flesh to be shaped onto the anthropological bones of the concepts of 'pollution and taboo', 'purity and danger' proposed by Mary Douglas (1966).[147] Both incidents are fine examples of pollution-avoiding, purity-seeking social interaction. In both cases the defenders of purity engaged in action whose justification and consequences become morally questionable themselves in the perspective of a critical socio-historical imagination. Each defended what they considered to be their 'sacred-codes'. Reform of them, or compromise with them, was interpreted as a threat to the very meaning of being a noble profession of such 'doctrines'. Reform or compromise, to purists, brought the threat of the dissolution of the basis of one's professional identity and cognitive security.

It is interesting to note that the findings of bacteriological-laboratory medicine received a similar response from homeopaths and regulars[148] and thus shaped their relationships in a very real way. Yet it was the experimental tools and methods of this very cosmology which could now put the veracity of homeopathic claims to the test, and that is (almost) what happened between 1908-1910. But before that point was reached the homeopaths suffered serious numerical and ideological decline.

4.5 The Decline of Homeopathy: 1890 Onwards

In 1874 the A.M.A. made a constitutional amendment which effectively denied the medical schools representation. This ratified their increasingly separate existences anyway. The schools identified more with the hospitals and clinics than the medical societies now the apprenticeship system was defunct.(149) The medical schools tried to improve educational standards by founding the American Medical College Association (A.M.C.A.). Unfortunately, the demands of commercial competition undermined its attempts and college support of the association plummeted, such that it suspended its activities from 1882-1889.(150)

Some improvements had been made prior to the 1870's but on the whole they were not uniform ones at all.(151) However -

"By the turn of the century, the situation was changing radically. In order to comply with the state licensing requirements and to attract students, medical schools were forced to make heavy investment in expensive laboratory equipment and to hire faculty on a full-time basis to teach the basic science courses".(152)

This was due to two main factors. First, the revolution of bacteriological-laboratory medicine, since the mid-1870's, had created a requirement for high quality, scientific, medical researchers. The response to this

was exemplified in the building of the Johns Hopkins University and Medical School in the late 1880's which sought not only to be the institutional exemplar of 'scientific medicine' but to provide an incentive for others to follow in the elimination of the defects of commercialized medical education.(153)

The Johns Hopkins Medical School was financed by endowment so that a full-time faculty of highly qualified practitioners and medical scientists could be established. They were drawn, not from local medical colleges as had been the former practice in such situations but from the nation as a whole. A four-year graded curriculum was established with pre-clinical education, laboratories and its own teaching hospital.(154) It was organized along the lines of the German University medical schools and required, for the first time in American medical education, a baccalaureate degree as an entry requirement... Thus:

"the extensive use of laboratories brought medical education in line with the developments of the bacteriological revolution".(155)

And so:

"Other leading medical schools took similar steps to incorporate scientific medicine into their curriculum through both increased scientific laboratory training and

direct application of scientific tools into clinical education. This necessitated hiring faculty in the basic medical sciences who were neither practitioners nor part-time teachers, but instead trained scientists who devoted their entire activities to teaching and scholarship".(156)

Second, the improvement in licensing requirements brought about by medical innovation and the relatively successful attempt by the regulars to standardize (and hence control) such criteria by the creation of the National Conference of State Medical Examining and Licensing Boards in 1891. With this Board the three year graded course became standard and with the unsolicited help from the reactivated Association of American Medical Colleges in 1889, the improved licensing conditions began to make unprofitable many of the poorer medical schools, be they regular or homeopathic.(157) Indeed, homeopathic schools were becoming more and more educationally similar to the regular ones under pressure of the pace of medical innovation, the apparent fruitfulness of the bacteriological revolution in epidemic diseases (e.g. diphtheria) and improved aetiological knowledge. With the apathy within the homeopathic ranks (especially the eclectic ones) towards traditional homeopathic therapeutics and materia medica,(158) and the financial support the regular journals gained, direct and indirect, from the proprietary drug industry,(159) homeopathic colleges were hardly different

from regular ones.

These events and trends had a disastrous effect upon the homeopathic medical schools. Numerically smaller than the regular profession [some estimate between 5-10 to 1 in favour of the regulars[160]] and concentrated in the north-eastern states it now lacked the wide base of public support necessary to adapt to these changes as well as the regulars had done.[161] Their colleges fell from 22 to 12 between 1900-1910, those of the regulars from 126 to 109.[162] The fact of the institutionally and cognitively divided professional homeopaths into 'high' and 'low' dilutionists did not help in these matters either.

The A.M.A. and its affiliated associations were gradually able to gain overall advantage in, and control of, licensure; especially after it had thoroughly reorganized itself such that county medical societies became its basic representative unit and it changed from being a de facto regional organization to a more truly national one.[163]

Between 1901 and 1903 a thorough reorganization took place such that the medical specialists were re-integrated into the membership of the local medical societies; the state and local societies were organized to co-ordinate their relationships to each other and the central A.M.A. administration; and membership criteria and policy was

standardized so that the medical societies became inclusive rather than exclusive bodies. All that was now required was for an applicant to show

"he was legally qualified to practice and that he was of reputable character (apparently regardless of his sectarian antecedents), and no county society could refuse him membership".(164)

In line with this organizational reform went a review of the code of ethics which basically established it as a set of principles rather than being treated as a piece of legislation, as previously. The details were to be left to the medical societies. As regards consultation with 'irregulars' it reflected the 1882 New York State Medical Society changes regarding emergency situations and demands of humanity. The attitude to irregular medicine radically altered also. The code said of sectarianism that it was

" 'inconsistent with the principles of medical science and it is incompatible with honorable standing in the profession for physicians to designate their practice as based on an exclusive dogma or a sectarian system of medicine' ".(165)

So as long as the homeopaths did not designate themselves as a specific, exclusive mode of practice they could consider themselves as regular physicians and entitled to all the rights of that role.

The rules regarding the defining criteria of irregular practice were now radically altered. The basis of exclusion was no longer that you practiced homeopathy but whether you claimed it to be an exclusive practice and, by implication, rejected all other modes of practice. Given that many homeopaths had said they did not reject all other practices - they just considered the homeopathic one the most important of them - then the previous hostilities no longer had good reason for being continued. Of the two main homeopathic, national institutions - the A.I.H. and I.H.A. - the former was clearly the most open to this change in formal relationships.

With the potential merger of homeopathy into regular medicine the problem facing them as a group was the loss of their distinctive identity and the probable demise of their medical schools.(166) With these problems facing the homeopaths it was rather late in the day for some regulars to start publicly admitting their own past, exclusivist and sectarian sins on behalf of the whole mainstream profession.(167)

With such open arms being offered by the regular profession and the problem of identity and distinctiveness which it created, the homeopaths tried to resolve the situation by convincing the A.M.A. leadership to arrange for the scientific investigation of the veracity of the Law of Similars. This was attempted between 1908-1910.

4.6 Conclusion; the Failed Pursuit of Scientific Legitimacy

This was not the first or the last attempt by the homeopaths to gain scientific legitimacy - consistently denied them by the delegitimating polemic of the regulars over the previous eighty-three years. They had gained considerable public status and a certain degree of professional respect, but scientific legitimacy was something they had constantly sought whatever the details of the dominant medical cosmology and related set of practitioners. Previously, such a test was not possible. Firstly, because of the intensity of passionate hostility against them which it would be difficult, if not impossible, for a heroic or clinical practitioner to escape from. Secondly, because the state of knowledge about drug action upon the human organism (whether ill or healthy) was inadequate and immature.(168) Thirdly, because of the inadequacy and immaturity of the aetiological knowledge of disease which could only be experimentally demonstrated - rather than merely argued about - upon Koch's published discoveries of 1876 on the anthrax bacillus.(169) Lastly, the tool subject of medical statistics was not sufficiently sophisticated enough to provide data that could conclusively settle the issue between regulars and homeopaths regarding claims for their own drugs and methodology and counter-claims against their opponents.(170)

In order for homeopathy to attain scientific legitimacy,

and hence be progressive, it had in a sense taken a hand in its own further decline. For the criteria of 'scientificity' were set by the medical researchers who were institutionally part of the regular profession of medicine. This is not to say they were anti-homeopathic per se but it is to recognise the fact that in terms of the bacteriological research programme then being pursued, issues about the truth or falsity of homeopathic doctrines were just not of any interest. As for the medical students their curriculum would necessarily exclude any substantive, systematic content about homeopathic theory and practice, except perhaps to disparage it in some way. This is not to suspect a 'conspiracy' by regular teachers to exclude homeopathic therapeutics from the curriculum but it is to say that the demands of imparting an integrated, graded system of medical knowledge and practice meant various items - often of historical interest only - had to be omitted. Thus the regular education system functioned as a huge filtering or screening mechanism - it screened out everything not relevant to the production of practitioners who were of good clinical and bacteriological knowledge and practice. In short, we can say <u>any</u> system of knowledge implicitly produces a system of ignorance about certain other aspects of experienced reality.(171)

By 1910 it was decided to test the principle of 'similia

similibus curantur' at either the Rockefeller Institute of New York or the McCormack Institute of Chicago. Kaufman (1971) simply states that for 'some reason' these institutes refused to take part in the experiment. Some investigation of the beliefs of the decision-makers at the Rockefeller Institute give a strong indication of why that institute refused to involve itself in the experimental testing of the Law of Similars.

John Davison Rockefeller (1839-1937), businessman and philanthropist founded the Rockefeller Institute of Medical Research (now Rockefeller University) in 1901, with the help of his only son - John Davison Rockefeller Jr. (1874-1960) - by his first wife, Laura Spelman Rockefeller. Rockefeller Snr. had retired from active business about 1896 but retained his title as president of the Standard Oil Company until it was dissolved in 1911 under a government anti-trust suit. He devoted the rest of his life, from 1896, to philanthropic action.(172)

The report of Abraham Flexner(173) published precisely at this time was based upon the assumed 'scientificity' and 'neutrality' of contemporary bacteriological research. This ideology of science and by implication the 'scientific medicine' then being taught by regular medical colleges and universities to thousands of students, had a deep influence in the decision not to test the homeopathic

doctrine of similars. The emphasis in regular medical education was on chemistry, physiology, pathology, histology, bacteriology, clinical microscopy, anatomy and surgery; this was in contrast to the importance which homeopaths placed upon the subjects of therapeutics, pharmacology, medical chemistry and toxicology. The actual Board of Scientific Directors of the Rockefeller Institute[174] included men such as Simon Flexner (brother of Abraham Flexner mentioned above) and William H. Welch, who were definite promoters of the claimed 'impartiality' of science and its assumed 'neutrality' between medical sects, cults and other passionately committed groups. All the members of this board, except Theobald Smith, were trained and studied in Germany, as well as having common interests in pathology and bacteriology.

Rockefeller Snr. tended to favour the homeopathic side of the conflict and regarded homeopathy as

"a progressive and 'aggressive' step in medicine".[175]

In fact his trusted family physician, friend and travelling companion was Dr. H.F. Biggar, a homeopathic physician.

However, the passionate commitment of Frederick T. Gates[176] (1853-1929) - Rockefeller's organizer, administrator and advisor on philanthropic programmes and projects, including medical ones - to the therapeutic nihilism of William

Osler's 'Principles and Practice of Medicine' (which he had read in 1897), led him to oppose the 'scientific' testing of the 'similia' principle. His arguments against sectarian medicine and the need for the Institute to be in favour of neither homeopaths nor allopaths (i.e. regulars) were supported by Rockefeller Jnr. This, combined with support for the ideology of 'scientific medicine' by the Board of Scientific Directors, led to the decision not to test the hard core of homeopathic theory and practice.

The alleged scientific impartiality of the Board is not supported by the fact that:

"In the ensuing decades Rockefeller's General Education Board poured money into allopathic educational institutions. The first grants in 1913 were for $1,500,00 to Johns Hopkins and $750,000 to Washington University of St. Louis for chairs in paediatrics, surgery and medicine. Between 1919 and 1921 more than $45 million was earmarked for Vanderbilt, Yale, Johns Hopkins, Washington University, the University of Ohio and the University of Chicago. All in the name of 'scientific impartiality' between homeopathic and regular medicine?"(177)

Thus, on the basis of the claimed neutrality and impartiality of scientific medicine the independent philanthropic institute of the Rockefeller's could refuse

to test the veracity, or otherwise, of homeopathic therapeutic claims. Yet three years later they could commit millions to selected medical educational establishments controlled by the historical successors of the heroic regulars. These successors may have been shaped by a different medical cosmology but they were part of that institutional and occupational continuity whose anti-homeopathic ideology had remained part of the implicit training and practice of the regular profession since the 1830's onwards.

The A.M.A. refused to make further arrangements. In the same year a bill to establish a Federal Health Department was supported by the A.M.A. as part of its strategy to gain greater licensing control. It was interpreted by the homeopaths as a move calculated to eliminate them. So some of them - together with osteopaths, patent medicine manufacturers and Christian Science healers - helped create the National League for Medical Freedom in order to oppose it. Together with the rejection by McCormack and Rockefeller institutes these events disturbed the homeopaths, especially when the regulars started to become hostile to homeopathic resistance over the proposed Federal Health Department. They closed ranks and some began to demand a return to the 'true faith' of Hahnemann. This demand was given expression at the 1910 meeting of the A.I.H. convention when a proposal was debated, to the

effect that in order to combat the new hostility of the A.M.A. any members who were also enrolled in regular medical societies should be expelled from the homeopathic ones. This proposal was defeated as it would have depopulated the A.I.H. itself. However, allies of 'allopathy' were labelled as 'traitors' and 'heretics'.

This denial of legitimacy meant that although the homeopaths could, technically speaking, become members of regular medical societies they were, in fact, still regarded as of 'pariah' status. They were accepted as members of local medical societies by the A.M.A. as long as they did not proselytize for or label themselves a homeopath, or assert that it was a superior and competing system of practice compared to the regular one. How they were accepted by the local societies was up to them, not the A.M.A. Some societies demanded that the homeopaths recant their past sectarian claims prior to joining, others placed no such purification rituals in their path. Some homeopathic members of regular medical societies were later expelled for refusing to give up their homeopathic associations.(178)

However, the reform of regular medical education, along the lines of the Johns Hopkins University and Medical School, improved licensing privileges and national reorganization of the A.M.A. took its toll of the professional

homeopaths and their own institutions, particularly their medical schools. The educational and organizational crises of the regular practitioners were overcome as the deployment of the rhetoric of science was accepted by the general public and they were able to 'control' an ideology in line with this to secure a system of legitimation for their professional recognition. The reform of medical education along 'scientific' (i.e clinical and bacteriological research) lines was the means whereby they were able to gain state, philanthropic, industrial and public support in their programme of increased occupational and social closure of the medical market. Those made marginal to and by this programme, through hostile exclusion or by a creeping absorption into mainstream medicine such that little difference existed between their practices, were forced to either adapt to the new occupational framework established by the A.M.A., licensing and examining boards, university medical schools and 'big-business' philanthropic foundations, or perish.(179) Many perished, whether regular or homeopathic institutions, but the latter were the worst hit. The whole process was compounded and intensified by the Flexner Report on medical education, published in 1910. Yet even at this stage in the development of the medical sciences and profession of medicine,

"medicine gained prestige not through enhanced therapeutic efficacy, but as a result of an increasing public faith

in the value of science".[180]

Within this framework of the utility of natural/scientific knowledge, innovation in the basic medical sciences contributed to the improved occupational status of the regular practitioners. Without needing to enter into details which only serve to repeat previous statements, the Flexner Report functioned to consolidate, intensify and extend previous reforms in medical education, along the lines of the Johns Hopkins University, Hospital and Medical School. Its ideology of science in medical education resonated with an ideal of the utility of scientific knowledge already pervasive in American culture, as in the application of 'scientific management' in big-business[181], philanthropic research institutes[182], public health reform[183] and the (limited) fruits of the bacteriological research programme. The Report also acted as an ideological matrix for the institutional co-ordination of the interests of the A.M.A.'s Council on Education (who commissioned the report), the Rockefeller Institute (Abraham Flexner's brother, Simon was first president of the institute), the Carnegie Foundation (whom the A.M.A. Council on Education commissioned to do the report) and developing university-medical school complex (the same people tended to be on the A.M.A. council, institute boards, and university-medical school staff).[184]

Against such momentous changes in American culture

and the medical profession the homeopaths continued to survive but only by creating their own cognitive ghetto in which to huddle for safety.

CHAPTER FIVE

HOMEOPATHY IN BRITAIN: ASYMMETRIES OF POWER, RECIPROCITY OF CONTROL AND THE ATTEMPT TO NEUTRALIZE A MARGINAL PRACTICE

5.1 Introduction

There exists no single comprehensive historical narrative of the development of regular medicine in Britain and neither is it my purpose to write one at this point. What I will do is to outline the main shape of medical organization, professional ideology, medical education and licensure, created by the regular profession of medical estates.

With this outline as necessary background, specific events and processes, relevant to the establishing and continuity of professional homeopathy, will be described. The main events dealt with in this framework are the institutionalisation of professional homeopathy and the response of the regular practitioners in the medical press and voluntary associations; the 1853-54 Cholera Epidemic and the attempt to suppress the homeopathic cholera returns from the government report of 1855; and the successful attempt by the homeopaths to be defined as 'registered practitioners' in 1858.

There are three conclusions I wish to draw. First, that

within the asymmetries of power, constituted by the system of medical estates, the professional homeopaths were able to establish a place for themselves by the mobilization of their own particular resources - patronage and distinctive medical practices. Second, they were able to manoeuvre, within this system of domination and subordination, enough to prevent themselves being treated unjustly in 1855, and politically eliminated in 1858. The capability to accomplish these things were instances of the reciprocal nature of control within a field of practice and practitioners increasingly dominated by a monopolistic regular profession.(1) Third, that the ideological conflict became ritualized at the level of the theory and practice of homeopathic medicine, its criticism and defence. In effect, further fruitful dialogue was rendered ineffective by the routinization of the vocabulary of conflict into a ritual exchange of criticism and counter-criticism by the 1840's.

5.2 The Organization of Regular Medical Practice: Estates and Corporations

For much of the nineteenth century there were three dominant estates of regular practitioners - physicians, surgeons and apothecaries. They constituted a tripartite, class based, occupational system of hierarchical stratification.(2) This was not only a social stratification based upon the degree of mental, manual or commercial

labour involved but also a moral hierarchy of honour and esteem, with the physicians at the apex who aped the manners of their aristocratic clients and presented themselves as university educated gentlemen.(3) Then followed the surgeons and apothecaries in the socio-moral status hierarchy. The surgeon was originally regarded as a skilful manual labourer, a craftsman whose knowledge was more empirical and tacit, than theoretical and discursive.(4) The apothecary was originally a commercial tradesman who due to aspirations of upward mobility and pressure from chemists and druggists, below him in the hierarchy, became the 'physician's cook'. He could charge for the preparing and dispensing of drugs but not for medical advice. That was the prerogative of the elite physicians.

Their institutionalised relationships were a reciprocal interaction - often conflict - over the extension and protection of work-task boundaries.(5) Neither were these three estates the only practitioners of the healing arts. There were pharmacists, grocer-chemists and druggists pressing up from below. Then there were various practitioners of herbalism and folk-medicine, women midwives and village 'wise-women' who provided relatively inexpensive services to the poorer classes.(6)

The main corporations representing these three medical estates were all institutionally and organizationally

established in England, Scotland and Ireland, with or without royal charters, by the end of the eighteenth century.(7) Some, like the Royal College of Physicians (London) were more interested in bolstering their own privileges than with promoting or reforming medical education.(8) Others, like the corporations of Edinburgh and Glasgow developed a link, if indirect, with medical education.(9) These different links with science and attitudes to change meant the Scottish corporations were better able to adapt to changes brought by science and politics.

In practice the powers of the corporations declined in the provinces. This enabled a style of practice to develop which combined the skills of physician, surgeon and apothecary in various combinations: apothecary-physician, apothecary-surgeon and surgeon-apothecary. Thus the tripartite division was more fluid in the provinces and a more general practice developed which involved physic, materia medica, surgery and midwifery.(10) This newly emerging role was produced by the exigencies of provincial practice and an important input by more broadly educated practitioners from Scotland.(11) However, the metropolitan Royal College of Physicians reasserted the tripartite status hierarchy through motions they were able to introduce into the 1815 Apothecaries Act which underlined its original tradesman, shopkeeper, commercial status.(12)

The 1858 Medical Act began a change in the estate system which, by the twentieth century, resulted in the unification of the profession and the subordination of other medical specialisms which posed any sign of a threat to the power of the doctor's medical decision over, and responsibility for, the treatment of his/her patients. In this way the domination of the medical division of labour, by a (now unified) regular profession, was reasserted but in a different way.(13)

5.3 Medical Ideology: Professionalism, Unlicensed Practitioners, Licensure and Medical Reform

Here we deal with various aspects of medical ideology which describe the public attitudes of the organised, regular practitioners. The elite physicians provided what was to become the ideological and institutional model for the later, post-1858, unifying profession of regular practitioners. The Royal College of Physicians (London) had an important function for upwardly mobile practitioners in this process.

The anti-quack ideology of the Royal College of Physicians also greatly shaped attitudes within the medical estates towards unlicensed practitioners. This ideology was simply extended to include non-orthodox practitioners like the homeopaths, even though they were as well educated and certificated as the regular practitioners themselves. Such an anti-homeopathic ideology was created by a regular

profession in crisis and confusion over its beliefs and practices. The homeopaths were a threat to their continued plausibility as a profession claiming to provide distinctive goods and services. The regulars therefore attempted, by means of the 1858 Medical Bill, to exclude the professional homeopaths from the legally recognized (regular) medical profession. They eventually failed to accomplish this objective because of the strategic mobilisation of patrons and supporters in the Commons, to suitably amend the Bill so that professional homeopaths could become registered practitioners. Such a capability demonstrates that the power exercised by the regulars was not, nor was it ever, total. The very fact of the exercise of power in relations of autonomy and dependence, domination and subordination, includes a reciprocal element in the matter of control. That is to say that the exercise of power is reciprocal in its direction and is an inherent feature of routine relations of power within social systems like the occupation of medicine. The subordinate and weak still have capabilities of turning their resources back against the dominant and strong.

Such an ideology towards 'unorthodox' professions and the attempts to express this through licensure and registration criteria has been tacitly imported into the history of medicine by regular practitioners taking up antiquarian interests. Accordingly the evaluations made by the regular

profession in its development have been assumed to be 'objectively' correct. This is because the model used to organize the historical materials about the development and contemporary facticity of 'scientific medicine' has been cumulative, linear and progressive in its guiding imagery at epistemological, methodological and narrative levels. Such a model is no longer tenable as an explanation of why homeopathy failed to gain legitimacy.

Finally, the main positions on medical reform will be identified and shown to be bisected by additional conflicts over whether reformist legislation should exclude or include the professional homeopaths. Even wildly radical reformers like Wakeley could be harshly punitive and illiberal when the issue of homeopaths arose in the political calculations of medical reform.

5.3.1 'Professionalism': the Model of the Royal College of Physicians (London)

The Royal College of Physicians (London) provided an occupational model for the accomplishment of 'professional' status by the other two estates and the emerging role of the 'general practitioner', particularly during the nineteenth century.(14) Accordingly its stance towards 'unlicensed practitioners' tended to be imitated. However, it failed as a model of medical reform during this century. This project was taken up by the upwardly mobile surgeon-apothecaries, apothecary-physicians and other

disaffected practitioners who were, or felt, excluded from the decision-making of the metropolitan corporations.

What was to be eventually called the 'Royal College of Physicians (London)' was given its first charter in 1511, and by 1523 it had become recognized as a 'professional' body providing a 'national service'. Although the nuances of the apellation, 'professional', changed down the centuries, at its core were the notions of a lengthy, basically intellectual, training; a recognized qualification; and its vocational character. However, sociologically the idea of an occupation being, or becoming, a 'profession' has more to do with self-perceptions and aspirations according to extant cultural models, than any set of so-called 'objective' traits or characteristics.(15) Even so, a common element in collective self-perceptions and legislative regulations of 'professions' is autonomy: the capability to be self-policing and relatively independent of non-member interference.(16) Also involved is a notion of the extent or jurisdiction of professional practice. For example, the London college of physicians was able, in 1523, to move its legal basis of legitimacy from the uncertain patronage of the Crown to the more secure patronage of Parliament. This increased its jurisdiction over the practice of physic from the seven-mile radius within the

City of London, to the whole of England. Concomitantly, its legal ability to repress unlicensed practice was also geographically enlarged, but its administrative and organizational capacity to do so was still difficult to carry out, as so many people used 'unlicensed practitioners'.

5.3.2 Unlicensed Practitioners

The original aims of the College remained intact throughout these extensions of its originally limited monopoly over the practice of physic. That is to say it was:

"a vocational body, charged with the repression of unqualified practitioners, with examining and licensing those who wished to practice, and with some kind of supervision over medicines".(17) (emphasis added)

The preamble of the 1511 Act, which gave the College legal existence, identified unqualified practitioners, or 'ignorant persons', such as:

'Artificers, Smiths [i.e. farmers], weavers, and women who use various noxious medicines, as well as a mixture of sorcery and witchcraft, which are against religion, as well as the proper practice of physic and surgery'.(18)

On the basis of these aims the College sought the enforcement of restrictive measures, throughout its long history, against those who were unlicensed and those practicing 'unorthodox' medicine. The deployment of an

ideology which assumed the legal, moral and cognitive illegitimacy of competing, unorthodox practitioners, was variously deployed against those labelled as 'empirics', 'quacks', 'mountebanks', 'deceivers' and so on.(19) Thus it was natural, later to label the professional homeopaths as 'empirics' and 'quacks' just because they were therapeutically unorthodox, in spite of their not being personally unlicensed or uneducated.

Even though such stigmatization of the homeopaths was carried out, in practical terms the regulars had no advantage, therapeutically, over them.(20) Neither did the regulars have any distinctive advantages over various other heterodox, but unlicensed practitioners, even by the mid-nineteenth century.(21)

The primary 'authority' for the differentiation of practitioners into 'scientific' (i.e. legitimate) and 'unscientific' (i.e. illegitimate) during most of the nineteenth century, was the enforcement of normative legal and occupational sanctions established by the regular estates. The rhetoric of 'science', the occupational ideology of 'professional service' and the authoritative resources of patronage, privilege and prior tradition, all functioned to accomplish and maintain the definition of medical 'reality' as constituted by the dominant hierarchy of estates.

Regular medicine not only deployed its pejorative anti-quack ideology against professional homeopaths but against a whole 'coven' of medical 'demons' such as mesmerists, phrenologists, hydropothists, herbalists and others. Such an ideology uncritically persisted in the founding of the history of medicine as a distinct discipline. This was because it was a field of study largely founded by regular practitioners distinguished enough in their own field to be able to give time to it.

Even with the advent of full-time 'professional' historians of medicine, like Richard Harrison Shryock - often more insightful than many - this anti-quack ideology was simply accepted as a proper evaluation of all those 'unscientific' things which went on outside of, sometimes within, the inevitable progress of modern, 'scientific medicine'. Until recently, that ideology has been largely unquestioned.(22)

5.3.3 Licensure

The various corporations were responsible for examining and licensing those who applied for membership, with the various advantages which that might bring for their practices. Some, like the apothecaries and surgeons had corporations who were also responsible for the education of their members in a significant way. The Royal College of Physicians (London) tended to separate the educative and licensing functions, dealing mainly with the latter.

The College was far more concerned with bolstering its own privileges.(23)

By the time of the 1858 Medical Act there were 21 licensing bodies.(24) In other words, a multi-portal entrance into the occupation of professional medicine existed; a situation to which the Act tried to bring some educational unity. It was nearly thirty more years before that was significantly achieved with the 1886 Amendment to the 1858 Medical Act. This later Act enhanced the powers of the General Medical Council regarding the minimum educational requirements necessary to be qualified for registration.

For much of the history of the medical estates, their work-task boundaries, expressed through and in licensure, circumscribed the tasks of physician, surgeon and apothecary in relation to the human organism. The field of 'the body' was divided up between them, more or less in direct relationship to their particular skills, privileges and responsibilities. Therefore, not only did the work-task boundaries provide a basis for an occupational status system of stratification but also produced a political economy of human anatomy.

The physicians largely practiced internal medicine. They did use the lancet but this was regarded by them as a therapeutic tool rather than a surgical instrument.

The surgeons specialised in the excision of external and internal lesions as well as the:

"everyday cure of wounds, inflammations.... dislocations, fractures; the removal of foreign bodies; catheterization; as well as scurvy, diseases of the eye and ears, skin diseases, and venereal diseases, the treatment of which the surgeon shared with the physician".(25)

The apothecaries, due to their commercial connections, were officially limited to the prescribing, compounding and dispensing of medicines. They could charge for medicines supplied but not for attending or advising the patient. The charging of such fees was the prerogative of the licenced physician. Therefore, physicians were paid for their intellectual labours; the surgeons and apothecaries for their manual labours.

However, wider social changes to the structure of Britain such as industrialization, urbanization and rising expectations regarding the quality of life, meant that the exigencies of actual medical practice often required the regular practitioner to be physician, surgeon and apothecary in a single role. Due to these practical demands of the medical market place, especially in the provinces, a self-conscious 'general practitioner' role was forged.(26) This, obviously placed increasing strain upon the legitimacy and plausibility of the tripartite

system during a time of widespread social and political reform.(27)

Such changes provoked attempts by the corporations to extend control over all types of medical practice in the face of the rise of the 'general practitioner'. The attempt to control and subordinate all types of medical practice, including chemists and druggists, was particularly apparent from the Royal College of Physicians (London). The attempts by the apothecaries to improve their status and resistance to it by the college of physicians continued up to the 1815 Apothecaries Act. By that time the London based Apothecaries' Company was so subservient and worn down by the resistance of the Royal College of Physicians (London) that the Bill which was finally enacted reasserted the tripartite status hierarchy. This reaffirmation was accomplished despite the extension of the supervisory and examination powers of the Apothecaries' Company to the whole of England and Wales. Therefore, the strategy of the College was able to allow various licensing and examination privileges in the 1815 Act but deny the apothecaries improved occupational status. The result was to continue to ignore the demands of the 'general practitioners' and the increasing irrelevance of the tripartite system of estates.(28)

By the time of the 1858 Medical Act, though, the Royal College of Physicians (London) had been able to

sufficiently modify its elitist ideology from one which denied anyone but physicians, professional status and privilege to one "which claimed elite status" for themselves but, "within an extended medical profession".(29) (emphasis added)

5.3.4 Medical Reform

The nineteenth century political tradition of industrial Britain had been set, a half century or more earlier, by political economists like Adam Smith (1723-90), political philosophers such as John Locke (1623-1704) and social reformers like Jeremy Bentham (1748-1832).

Debate about medical reform was organized between the twin poles of laissez-faire market freedom and elitist occupational autonomy. Since pure laissez-faire was a minority position the reformers' debate regarding the regular medical profession was one over the degree and kinds of government restriction to enact. The question of whether or not to enact restrictive measures was not a basic issue.(30)

The ideologies of medical reform fell into three main types by the 1850's. First, what may be termed the conservative reform position stated by Mr. Thomas E. Headlam (1778-1864), a prominent physician and reformer from Newcastle-upon-Tyne. This position argued for an independent but representative medical council. Although it is difficult to

see how it could be independent and representative, except in a purely technical legal sense. [If it was to be representative of the licensing authorities it would not in fact be independent of them]. Existing licensing arrangements would function as 'de facto' medical registers.

Second, a moderate reform position represented by Lord Elcho (1818-1914). They proposed a single-portal entry system with registration of qualified practitioners. A medical council would be answerable to and nominated by the Commons. Corporation and university medical examinations would be optional for practitioners wishing to practice and be registered.

Third, a radical reform position in the spirit of Thomas Wakely, led by his successor Mr.Thomas S. Duncombe. They wanted the legislative elimination of the corporations and legal equality for all qualified practitioners.

These positions on medical reform were variously divided over whether legislation should be restrictive or definitive in its specific proposals. That is to say:

"Restrictive measures limited practice to licences and made it an offence to practice without a licence; definitive measures regularised by definition - at least to the extent of making it an offence to use a title for which one had not qualified, but otherwise permitting medical

activity".[31] (emphasis added)

It is interesting to note that a radical reform position like Wakeley's and Duncombe's was harshly restrictive when considering the place of professional, licensed but homeopathic practitioners. Indeed, as we shall see later (section 5.6.2) it was the work of the homeopaths and some parliamentary supporters who transformed a restrictive medical bill into a definitive one. They thus reasserted the dominant British political tradition of liberalism in the matter of how registered practitioners were to actually practice their art.

The medical reform movement of the first quarter of the century began to produce reform bills by 1840. It was seventeen years and seventeen bills later that the 1858 Medical Bill - suitably amended by the homeopaths - received royal assent on the 2nd. of August and became legally effective as from the 1st. of October of that year. Its basic purpose was to enable the public to differentiate qualified from unqualified practitioners by the creation of a medical register. This was supervised by a General Medical Council responsible to the Privy Council. The Act also provided a limited but later extended monopoly of all government medical posts. Ideologically the regulars were able to monopolize representation on the General Medical Council and exclude registered homeopaths from further political legitimation on the basis of acts

of parliament.

5.3.5 A Point of Comparison with the United States

In contrast to Britain the work-task boundaries of the regular practitioners in the United States were not such a legally defined status hierarchy. Although organized in terms of voluntary medical associations, as a profession they occupied a more fluid and flexible role in relation to practices. This was because the demands of Frontier America required practitioners to be physician, surgeon, apothecary, dentist, midwife and sometimes 'horse-doctor' all in one. In fact, the contribution of Edinburgh trained practitioners was significant for such a general medical function.(32) Of course, some physicians did seek to establish an elitist set of medical associations and schools, but the wider political culture of populist democracy effectively operated against a British style elitist status hierarchy.(33)

It was this greater social fluidity and anti-monopolistic ideology which enabled the heterodox, anti-heroic medical reform movement, in the United States, to be so successful in opposing the licensure monopoly of the regulars. However, it was probably that same fluidity and lack of the legislative definition of medical practice which enabled regular medical societies to use various informal exclusion mechanisms to purify themselves of known and

'closet' homeopaths. By contrast, regular practice in Britain was legislatively circumscribed. This probably made it easier for professional homeopaths to identify specific attempts to either, alter legal definitions to operate against them, or, to enact new definitions which did much the same. For instance, the 1858 Medical Bill, just before it received royal assent, would have permitted the regulars to legally persecute professional homeopaths and exclude them from registration, no matter how well qualified they were. Only the timely intervention of the homeopaths and some Parliamentary supporters averted that attempt at elimination through restrictive legislation.

5.4 Medical Education

In what follows I will outline the poor state of medical education and the main legislative attempts to reform it and the profession generally. This will provide the last piece of background on the regular profession before we move on to various events in the development of professional homeopathy.

Physic had been a library-based 'science' for centuries and involved little manual experience for the physician. In point of fact:

"Except for dissection and surgical operations, the whole of medical education before 1800 could be done in the lecture theatre. That was what made it so easy to set up

a private medical school".[34]

Heroic medicine dominated much of the first half of the nineteenth century, mainly at the level of day-to-day practice. The clinical-hospital cosmology began to change that style of medicine from about the 1820's. The patho-physiological diagnostic procedures and tools it provided were in more general use in London hospitals by the mid-century.[35] This was partly due to the diffusion of the training of many English medical students in its theory and procedures as they returned from the general Anglo-American movement to the medical Mecca of Paris during the early nineteenth century.[36]

However, although it may have taken up to eight years or more to qualify as an M.D., via a classics education beforehand, it was still possible to be certificated as a physician without having treated a patient. Even failing a medical examination was no necessary bar for licensure since St. Andrew's College and Aberdeen University could provide a qualification for the requisite fee of about £5.[37]

The multi-portal licensing system of entry into regular practice thus left each licensing authority to prescribe its own standards of professional education and practice.[38] Added to this were the private medical schools which relied completely upon student fees for their continued

existence. Together with the apprenticeship system these various bodies produced a medical profession of an extremely uneven educational character.(39)

5.4.1 Educational Reform

Between 1830 and 1858 there arose a strong demand for educational and organizational reform of the regular profession. Indeed the reform of education generally was being campaigned for during this time.(40) The medical reformers presented various proposals for organizational change, as we have seen (section 5.3.4), which would bring some kind of legislative and occupational unity to the whole field, as well as enable practitioners and public alike to know who was a certified, licensed (hence 'legitimate') practitioner and who was not. Some sort of registration procedure was proposed. The Royal College of Physicians (London) favoured a tripartite based register, which would leave their licensing privileges intact. Radicals like Wakeley proposed a single register which would eliminate the privileges of the corporations. These reform proposals were not only responses to wider social and political changes but also to internal and external criticisms about the poor quality of medical education. Then there were the increasing anxieties evoked by the apparent increase in the numbers and activity of not only unlicensed practitioners but also heterodox, professional practitioners like the homeopaths.

Added to this were the epistemological, methodological and therapeutical uncertainties of a crumbling heroic medical cosmology as it was gradually displaced by the principled uncertainties of therapeutic scepticism, enshrined in the emerging clinical-hospital cosmology.

5.4.2 The Apothecaries Act of 1815

The first major (but largely failed) attempt at the reform of medical education was the 1815 Apothecaries Act. This has been traditionally regarded as a major advance. In fact it was more of a retrograde step because it required the apprentices of apothecaries to undergo five years of training. It did bring some advantages to the Apothecaries' Company, as has been mentioned already (see section 5.3.3). However, it can no longer be viewed in such a celebratory light as previously.

On the whole, the resistance of the Royal College of Physicians (London) to the 1815 Apothecaries Bill and the compliance of the apothecaries themselves, enabled the physicians to insert wholesale amendments to it. The overall effect was to reassert the tripartite hierarchy and hence the lowly commercial status of the apothecaries, within the total system of status and privilege.

By 1832 the requirements of the Apothecary's Company, for qualifications to practise as an apothecary included:

" 1. In translating parts of Celsus' 'de Medicina' or Gregory's 'Conspectus Medicine Theoreticae', Physicians' prescriptions and the 'Pharmacopoeia Londinensis'.

2. In chemistry.

3. In materia medica and therapeutics.

4. In history.

5. In anatomy and physiology.

6. In the principles and practice of medicine (including diseases of pregnant and puerperal women and children)."(41)

The Royal College of Surgeons (London) provided a similar set of regulations but with necessary emphasis on surgery and anatomy, with additions possible such as botany, forensic medicine, clinical medicine and physiology.(42)

In the provinces, the regular practitioners licensed to practice the skills of surgeon and apothecary were growing in numbers. They were responding to the exigencies of practice and competition, especially from unlicensed practitioners.(43) Developments of this kind began to radically undermine the formal tripartite system. However, the Royal College of Physicians (London) could only respond by reasserting the old system. The rejection of recognition for 'general practitioners', such as apothecary-surgeons,

provoked an increase in the formation of provincial medical societies, medical book clubs and other means of catering for the aspirations of a growing number of such practitioners.(44) The corporate elites were no longer meeting the occupational needs of the rank-and-file who were now clamouring for reform of the whole system of professional medicine.(45)

5.4.3 The 1858 Medical Act

A certain amount of reform was accomplished prior to the 1858 Medical Act through the medical schools. They broadened their curricula, lengthened the duration of study and developed closer links with the universities and hospitals.(46) The hospitals began to provide more practical experience in the wards and an apprenticeship system began to develop for students, within the teaching hospitals. This could lead on to a career in medicine, or surgery.(47) However, it did have its drawbacks:

"From the standpoint of medical students, the establishment of medical schools and the growth of the curriculum at first expanded their options but, in the long run, brought them under the firm control of their seniors in the medical world".(48)

The passing of the 1858 Medical Act was a step in the direction of the eventual creation of a unified regular, monopolising profession of medical practice by the early

twentieth century. It also signalled the beginnings of the increasing standardization of what constituted a (minimal) medical education. The General Medical Council, which administered the register, was concerned that the corporations be able to produce the 'safe general practitioner' whom they could be certain had attained a certain standard of medical education. The response of the various institutions was to tend to overcrowd the curriculum in an attempt to produce this 'safe general practitioner' in the following generation of students. Vocational (i.e. useful) knowledge began to crowd out the more general, literary or 'cultured' subjects. One of the results was that the Army was rejecting candidates for medical posts, on the grounds of illiteracy, as late as 1890.(49)

5.4.4 Post-1858 Educational Reform

The General Medical Council was involved in various conflicts with the corporations and universities over its powers of inspection regarding the standards of medical instruction. The basic issue was over whether its powers were purely administrative (as the corporations and universities insisted) or legislative (as the Council and various reformers insisted). It was not until the 1886 amendments to the 1858 Medical Act that a minimum standard of pre-medical education was set out and candidates for examination were required to qualify in medicine, surgery

and midwifery, before they could be licensed and registered.(50)

However, the universities had begun reforms prior to this which anticipated the new minimum requirements. They began by increasing the three year course to four and later five, in order to provide a year of 'apprenticeship' after graduation.

The 1858 Medical Act and its 1886 amendments advanced the course of standardization in medical education in line with the increased knowledge and innovations of the basic medical sciences of anatomy, physiology, pathology, chemistry, surgery and, by the last quarter of the century, bacteriology. The 1858 Act was also -

"the major landmark in the rise of the apothecary and of the surgeon from the lowly status of tradesmen and craftsmen and their assimilation into a unified profession with the higher status physicians".(51)

Not only were reforms in medical education responses to medical innovations, demographic changes and the exigencies of patient demand but also the continuing experience of various public health problems, especially cholera epidemics. These epidemics occurred in 1831/32, 1853/54 and 1866/67. They certainly must have 'inspired' medical reformers to improve medical education and thereby the quality of the regular profession. Public health reforms

also improved life-chances as the century advanced. However, the immaturity of aetiological knowledge and the ineffectiveness of regular therapeutics, especially against cholera, continued until the fruits of the 'bacteriological revolution' began to be felt during the 1880's and 1890's. Yet, the homeopaths had demonstrated the 'superiority' of their cholera treatments during the 1853/54 epidemic. It was a result which some regular clinicians attempted to suppress, but failed. They were not prepared to admit to the homeopaths, nor themselves, that homeopathic therapeutics (in cholera at least) were significantly more 'effective' than either heroic, neo-vigorous, or sceptical therapies. Still, conservative and sceptical therapies relying upon the 'vis medicatrix naturae' were certainly a welcome change from the previous heroic régime.(52)

5.4.5 Conclusion

The reform of the medical profession, in terms of its educational standards, certification, licensing and registration requirements, developed in tandem with its attempts to suppress both unlicensed and unorthodox practice. In short, the processes of monopolisation, occupational closure and marginalisation are all part of a seamless web which mutually reinforced each other in specific ways and directions. Some historians, like Margaret Pelling (1983) have charged sociologists of

medicine with proposing a model of medical monopolisation as -

"a middle-class conspiracy aimed at the self-interested control of a particular market, any reference to the public interest being either disingenuous or superficial".(53)

Such a judgement fails to distinguish the different but complementary methodological levels at which the historians and sociologists of medicine have traditionally operated. The sociologist of medical monopoly has traditionally dealt with the institutional analysis of system properties. That is to say, the analysis of the rules and resources of collective action reproduced as features of social systems over time and space. The historian of medicine has traditionally dealt with the analysis of strategic conduct. This is the attempt to view system properties from the perspective of the actors drawing upon the rules and resources of that system in the accomplishing and enactment of their social relations.(54) To fail to perceive such a distinction, between the analysis of system and social action, as methodologically differentiated approaches to the same phenomena of the structuring of human agency, is to fundamentally misconceive the monopolisation thesis by trying to make one perspective answer to the methodological criteria of a complementary but distinct perspective, with its own criteria of adequacy.(55)

It is not that the sociologist ignores the motives of agents for their action, it is just that he/she often tends to explain the outcomes of such actions in institutional or system terms. This approach does not accord individual motives primary ontological significance in system outcomes or structures. However, there is no methodological reason why sociologist and historian cannot operate in terms of each methodological perspective, depending upon the problematics they are attempting to solve. In fact they often do this in their disciplinary practices.(56)

With this caveat we will now move on to consider some significant events in the development of professional homeopathy within the framework of the asymmetries of power and structures of domination - ideological and legislative - which existed during the nineteenth century.

5.5 Creating the Style and Tone of an Ideological Conflict

This and the previous chapter are important as an historical basis for the elaboration of a descriptive theory of marginality in the chapter which follows. The theory functions reciprocally and in conjunction with the Weber-Berlant thesis on monopolisation, explicated in chapter one. The following accounts are intended to make three basic points.

Firstly, the establishment of professional homeopathy as an

institution in the "longue durée of historical time"[57], was no easy task. Neither did it end when they gained political legitimacy as 'registered practitioners' in the 1858 Medical Act. It was a constant accomplishment in the face of a hostile regular profession.

Secondly, the conflict with homeopathy had become a ritualised and stagnant debate by the 1840's. It was not that it had entered a "degenerative problem shift"[58] but rather that the deviantizing vocabulary of insult had never allowed it to successfully present itself as in a progressive state to begin with. Regulars generally perceived it as already 'degenerative' and in a wider sense than merely the theoretical.

Thirdly, within the asymmetries of power and structures of domination already described, the professional homeopaths were still able to exercise a reciprocal measure of power in their own right. Two events will demonstrate this capability. They are selected not merely to repeat a point but because both are important in the development of homeopathy as such and the self-perceptions of the homeopaths as 'victims' of the 'blind prejudice' of the regular profession. The events are, (a) the failed attempt to suppress the homeopathic cholera returns from the 1855 government report on the 1853-54 Cholera Epidemic; and, (b) the failed attempt to annihilate the homeopaths, cognitively and politically, by excluding them from the definition of

a legitimate 'registered practitioner' proposed in the Medical Bill of 1858.

5.5.1 The Institutionalisation of Homeopathy: Patronage and the Response of the Regulars

(i) Frederic Hervey Foster Quin (1799-1878)

Frederic Quin was the first professional practitioner to introduce homeopathic theory and practice to Britain, possibly as early as 1827 but certainly by 1832.(59) He was converted to homeopathy in 1826 by one of Hahnemann's disciples whilst in Naples. It was not only this Dr. Necker who convinced him of the efficacy of homeopathy, but also the success of a visit to Hahnemann and clinical instruction from a group of his followers practising in Leipzig.

This was not the first time Quin had encountered homeopathy. Whilst travelling on the Continent during the 1820's Quin fell ill (1823) and was successfully treated by Dr. Romani, a homeopath, and physician to Queen Marie Amelie of Naples. Romani was also a convert of Dr. Necker. From this experience Quin's interest in homeopathy grew and he read Hahnemann's "Organon" and "Materia Medica Pura" in 1824. He even successfully treated, homeopathically, his first patient under that system, an artist by the name of Thomas Uwins.

"Uwins' brother was a doctor who took up Homoeopathy with tremendous enthusiasm, defended Quin's honesty at the

Medical Society of London, and indeed wore himself out in the controversies with the English allopaths".(60)

Quin was a regular trained graduate of medicine from Edinburgh University. Whilst there (1817-20) he had not only come under the influence of Professor James Gregory (1753-1821), successor to William Cullen (1712-90) in the chair of the Practice of Medicine, but also Dugald Stewart (1753-1828) in moral philosophy. Qualifying in 1820 Quin received the patronage of the Duchess of Devonshire. Through her connections he was to have been appointed to replace Dr. O'Meara as physician to the captive Napoleon Bonaparte, on St.Helena. However, before Quin could embark from Italy to the island, Napoleon died (1821).

Whilst travelling on the Continent he made many aristocratic connections which were to prove crucial in the later establishing of professional homeopathy in Britain. In 1815 he was in Paris to learn French and struck up a friendship with Count Alfred Guillaume D'Orsay (1801-52) which he renewed during the 1820's while travelling as physician to the Duchess of Devonshire. He developed what was to be a crucial friendship with Lord Robert Grosvenor (1801-93), third son of Robert Grosvenor (1767-1845), first Marquis of Westminster, while in the Duchess' employ. It was Lord Robert Grosvenor who, as a seasoned M.P. for Middlesex (1847-57), was later instrumental in presenting the homeopaths' case to have their 1853-54 cholera returns

published in the 1855 government report. The returns had been excluded, for decidedly unprofessional reasons, by a clique of regulars on the Treatment Committee of the General Board of Health. Such aristocratic connections were important to the growth of interest in and eventual institutionalisation of Homeopathy from 1832 onwards.

After he had converted to homeopathy, in 1826, Quin was introduced to Prince Leopold of Saxe-Coburg (later King of Belgium) and appointed as his physician (1827-29) whilst the Prince visited England. His former patron, the Duchess of Devonshire, had died of pneumonia in 1824. Leopold was related to English royalty by his marriage to Princess Charlotte of Wales, second in succession to the throne, but who had died in child birth. Quin and Leopold arrived in England, from Leipzig, in 1827 and Quin began to practice homeopathically. His patients were known as 'Quinnites', as Hahnemann and homeopathy were generally unknown in England at that time.(61)

Between 1829-31 Quin returned to Paris. In September, 1831, he heard of a cholera epidemic raging in Moravia and decided to put homeopathy to large scale test. He contracted the disease himself whilst there but recovered under homeopathic treatment. With over 600 cases he achieved 95% recovery, compared to only 50% by heroic practitioners.(62)

Returning to London in July 1832 he set up his homeopathic

practice but immediately fell foul of the censor of the Royal College of Physicians (London), Dr. John Ayrton Paris (1785-1856). He sent Quin notice that he should stop practising in London without their licence. Quin ignored it and everyone's attention was quickly taken up with combating the 1832 cholera epidemic. This outbreak claimed more than 30,000 victims.(63) It was during this epidemic that a homeopathic colleague of Quin's, Dr. Dunsford, successfully treated Henry William Paget (1768-1854). He was Marquis of Anglesey and a war hero of the Battle of Waterloo. Dr. Dunsford treated him for a case of tic douloureux. This was a type of trigeminal neuralgia, a painful neuro-physiological illness. Yet, Dunsford was able to provide relief from the pain of the neuralgia for up to eighteen months at a time. It brought him great notoriety and the homeopaths an eminent supporter.

Important for our later study of the 1855 attempt to suppress the homeopathic cholera returns, is the fact that in 1834 Quin was proposed for membership of the Athenaeum Club(64) and Dr. John Ayrton Paris organised forty colleagues from the Royal College of Physicians (London) to black-ball him. Paris was one of the three censors additionally appointed to the Colleges' committee on medical quackery in 1830.(65) This would probably have 'sensitised' him to Quin's 'unorthodox' practices, perhaps overly so. It may have been coincidental that it was Paris who wrote

to Quin in 1832 to request him to cease practising without a licence from the College, but there was nothing coincidental about his vehement opposition to Quin's nomination for election to the Athenaeum. Indeed his opposition extended to slanderous accusations against Quin and his homeopathic beliefs.(66) Unable to let Paris get away with this slander Quin, upon the advice of his friend D'Orsay, challenged Paris to a duel. Paris refused and had to make a public apology to Quin. Therefore, it is decidedly not coincidental that the cholera Treatment Committee, with Paris as its chairman, tried to suppress the returns of a hospital at which Quin was the chief physician.

Despite the apology, the blackballing of Quin stood. This was the only time that he made a public response to a personal attack. It was to be characteristic of him, and the British Homeopathic Society (B.H.S.) which he founded, to be careful to provide no grounds for ethical complaints from the regulars. He was also careful to maintain the 'professional' and 'scientific' status of the homeopathy practiced and propagated by the B.H.S.. This was why he steadfastly resisted the popularising of it by lay, or even professional, propagandists.

Reverend Thomas R. Everest was one such propagandist who had been a patient of Hahnemann's. An Anglical clergyman and Rector of Wickar in Gloucestershire, he was the first

to write on homeopathy in English. However, he was rather eccentric in his homeopathic views and tended to see the principles of homeopathy as prefigured in the bible. He interpreted homeopathy as the physical means of salvation which completed the spiritual means provided by biblical revelation. Such a spiritualising of Hahnemann (and the bible) appealed to clergy like Everest. He later had leanings towards Swedenborgian 'enlightenments' during the 1850's.(67) Such interests were part of the general interest in metaphysical idealism, positivism, materialism and other philosophies at this time.(68)

In conclusion, we can say that Quin gathered some powerful patronage to his cause: the Grosvenors, Pagets, Prince Leopold's connections with royalty, the Devonshires and many others of the highest ranks of the Whig aristocracy.(69) In an age of 'polite society'(70) with its subtle rankings of status and honour, Quin was patronised -

"as much for his social acceptability and his bedside manner as for his medical skill".(71)

(ii) The British Homeopathic Society Founded

Quin had tried to found a homeopathic society in 1834 but the five who met with him could not agree upon the proposed regulations.(72) He tried again in 1844, the year after Hahnemann's death, when he invited ten colleagues to his home to commemorate Hahnemann's birthday. From this

meeting the B.H.S. was founded on the 10th. of April, 1844. Of the ten founding members the B.H.S. records mention seven by name: they were doctors Quin, J. Gilish (or Gilioli), Maque, Partridge, Nagel and J. Epps, and a surgeon, Mr. W. Ward. Epps withdrew before the society was officially founded and organized the lay homeopathic movement by helping create the English Homeopathic Association (1845) as a means of focusing such interests. The remaining six members became nine with the addition of doctors J.R. Russell and J.J. Drysdale, and a second surgeon, Mr. Cameron. By the 14th. of May, 1844, the officers of the society were elected. They were Quin (President, 1844-78), Gilish (treasurer) and Ward (Hon. Sec.).

(a) Membership and Organization

The society established five classes of membership: Inceptive, Full, Fellows, Corresponding and Honorary. Inceptive members were students and qualified practitioners interested in homeopathy but not practising it exclusively. Full members had to be qualified practitioners who were practising homeopathy exclusively. They could participate in all the societies' business and elect new members or fellows. Fellows had to have been in practice for seven years, of which the previous five were to have been practised according to homeopathic principles and methods. A Fellow was also to have been a member of the Society

for two years, and written two communications and a dissertation on homeopathy. Homeopaths outside Britain could become corresponding members. Retired homeopaths and those in the auxiliary sciences were able to become honorary members. Two thirds of full members could elect fellows and only fellows could become officers of the Society. Local branches could be established if there were at least nine homeopaths and the B.H.S. president authorised it. However, branches were only permitted to elect inceptive members and any papers presented at them became the property of the parent organization in London. Members could be expelled for advertising, claiming qualifications they did not have, and selling secret remedies.(73)

Like the corporations of London physicians and surgeons, the B.H.S. was a hierarchical organization with election to its executive offices the prerogative of fellows only. Although it had no statutory licensing privileges it only permitted full membership to long-standing, certificated/licensed practitioners. However, unlike those corporations it did allow its members opportunity for active participation in the Society's business. Members were permitted to stay in general practice as long as they practised homeopathy exclusively. In principle it was a national organization. In practice it suffered just as much as other London-based medical societies from the predominance

of metropolitan members at its regular monthly meetings.[74] It did differ from its elitist counterparts in that its governing body was open to any of its members, provincial or metropolitan. However, in practice the difficulties of getting to London for widely scattered provincial members (e.g. Edinburgh, Newcastle-upon-Tyne, Leeds, York, Bristol) produced a 'de facto' metropolitan controlled executive. For instance:

"Of the 14 Fellows elected by the end of 1846, 11 were M.D's and 9 were practising in London".[75]

The conflict between metropolitan and provincial members[76] was resolved in 1849 but seven members left the Society as a result.[77] A few rules were changed but the metropolitan centre and Quin's leadership were re-affirmed. Time was then taken up with establishing a homeopathic hospital in London (1850) and organizing its patronage and management. A year later the B.H.S. was involved in forming "The Association for the Protection of Homeopathic Students and Practitioners" as a defence organization for lobbying university and civic bodies in situations where (a) students were being deprived of medical diplomas because of their homeopathic interests, and (b) homeopathic practitioners were being excluded from regular medical societies because they practised homeopathically.[78]

(b) Consolidating Commitment

From the perspective of a sociology of conversion, the types of membership of the B.H.S. can be interpreted as a system of available organizational roles 'designed' to manage the identity consolidation of new converts to homeopathic beliefs. They also functioned as mechanisms and indicators of member commitment, means of professional identity and role allocation. For example, those interested in investigating homeopathy became inceptive members and were organized into 'inquirers' groups. These groups met to read and discuss a paper on some facet of homeopathy, usually of general or foundational interest to new members.(79) Meetings not only consolidated the cognitive identity of the convert but helped the inquirer to construct one, also affirmed the identity of the full members who often gave the paper and guided discussion. (This analysis is elaborated in some detail in chapter 6, section 6.4.5).

Commitment was reinforced as career opportunities to practice in homeopathic hospitals and dispensaries were created in London, Leeds, Liverpool, Bristol, Newcastle-upon-Tyne and Edinburgh. The necessary separate institutional development of organized homeopathic practice in urban centres did tend to underline their 'outcast' status with the regulars. However, they did not perceive themselves as equivalent to (other?) 'irregular' (i.e unqualified,

unlicensed, and after 1858, unregistered) practitioners.[80] Therefore, they refused to consult with 'irregulars' as defined by the 1858 Medical Act.[81]

(c) Standardizing and Consolidating Homeopathic Knowledge

Dependency upon homeopathic dispensing chemists and pharmacists, after 1858, brought the issue of the standardization and improvement of homeopathic preparations to the attention of the B.H.S. It proposed and commissioned a new 'British Homoeopathic Pharmacopoeia' equivalent to the one instituted by the General Medical Council. The Society also proposed a new 'Materia Medica' and text-book on 'The Theory and Practice of Homoeopathic Medicine'. The new pharmacopoeia was published by 1870 and copies were sent to colleagues in the United States.

Two years before Quin died (1878) and Dr. Robert E. Dudgeon became B.H.S. president, the 'London School of Homoeopathy' was established. By 1882 it was granting diplomas and licentiates in homeopathic medicine. Its president and chairman were both from the Grosvenor family.[82]

The purpose of the school was two-fold. First, to meet a need for education in homeopathic materia medica and therapeutics. Second, to protect the public from unqualified homeopathic practitioners. Entrance to the school was therefore limited to qualified, registered

practitioners and interested students from recognized medical schools. Clinical instruction and 'apprenticeship' was available for the school's students on the wards of the London Homeopathic Hospital.

However, the B.H.S. was opposed in principle to the giving of the 'Diploma of the Licentiate of Homoeopathy' by the school.(83) They considered it as trading upon a name and infringing their rule about assuming titles not given by legally recognized medical institutions. In short, they regarded the diploma as sectarian, illegal and worthless. Opponents to this view argued that they were regarded as sectarian anyway. Also, many such schools gave diplomas, whether they were chartered or not. It was pointed out with some irony that membership 'titles' of the B.H.S. were only honorary and not legally recognized either. Despite this dispute over principles and 'professional' image, the school certainly helped in the standardization of homeopathic knowledge and practice, as well as functioning to maintain its institutional continuity.

In conclusion, we can say that the B.H.S. had internal problems of organization and member commitment comparable to those of similar institutions throughout the century but because of the besieged nature of their existence a considerable internal solidarity was generated. Although their patrons worked quietly behind the scenes they were quite prepared to defend the interests of homeopathy

against injustice and calumny, as in the case of the 1855 Cholera Report and 1858 Medical Bill. The B.H.S. was an elite organization which was concerned to win over the regular profession by their personal and corporate 'professionalism', integrity and intellectual quality. However, because of these internal aims and ideals, professional homeopaths found it difficult, if not impossible, to understand how their regular professional 'brethren' could continue to hate and reject them so much when they were making tremendous efforts to minimize the difficulties between them.(84)

(iii) Medical Knowledge and Political Interests: Elite Versus Populist Interpretations of Homeopathy

The elitist interests of the professional homeopaths were evident not only in the hierarchical organization of the B.H.S. but also in the view of medical knowledge developed by the Society and the 'British Journal of Homoeopathy' (abbreviated to B.J.H. henceforth).

The B.H.S. and B.J.H. argued for a view of medicine as practised by a well educated, qualified elite. With their expert knowledge of the inner processes of the human body, homeopathy could be established on a 'scientific' footing. This paralleled the political interests of the main patrons of professional homeopathy, who were part of the Whig aristocracy. This section of the aristocracy was committed to reform in principle but in practice was

supportive of the traditional, aristocratic social order. The medical profession reflected this in their own organization. Just as government was to be practised by those qualified by birth and experience, so professional medicine was also to be practised by a comparable elite.

The B.H.S. and B.J.H. interpreted Hahnemann's original symptomologically based, transcendental (anti-materialist) therapeutics, in a way which accorded with the broadly sensualist, materialist, patho-physiology of clinical-hospital medicine. B.J.H. pages were open to all those who admitted the 'similia' as a therapeutic principle, whatever other shades of medical opinion were held. This made professional homeopathy quite a 'broad church' organization. The main interest was therapeutics but other auxiliary branches of medicine were not neglected. Indeed, 'modern', non-speculative, pathology was regarded by them as

"a <u>pure science of observation</u>.... not only compatible with, but absolutely necessary to, the perfection of the Homoeopathic method".[85] (emphasis added)

The B.H.S. and B.J.H. interpreted Hahnemann in a way which was ideologically supportive of their self-perception as a professional, scientific elite of medical practitioners, manipulating esoteric knowledge of the inner workings of the body.

Such an ideology resonated with the elitist political

ideology of their Whig patrons in the sense that, just as the medical elite had special knowledge about the inner workings of the human body, so they as a political elite had special knowledge about the inner workings of the political 'body'. Only they were able to govern, because just as the presenting illness symptoms of the human organism could only be properly interpreted and remedied by a medical specialist, so the presenting symptoms of a 'sick' society (i.e. conflict and unrest) could only be properly diagnosed and remedied by a political 'physician': the aristocratic political elite.(86)

Such an ideology was in direct contrast to the more radical and idealist interpretation of Hahnemann provided by Dr. John Epps and the 'English Homoeopathic Association' (abbreviated to E.H.A. henceforth). The E.H.A. was the unashamedly populist, lay counterpart of the B.H.S. Its ideology of medical knowledge was accordingly anti-elitist. It emphasised the symptomological, hence publicly available, exoteric knowledge of homeopathy. This resonated with its political ideology of popular radical reform in line with the interests of the working and middling classes. It conceded no hidden mechanisms or processes to the political 'body'. The symptoms of unrest/illness were understood as clear and undistorted signs of the causes of unrest/illness. As such they clearly indicated the solution to the problem/morbidity. In short, a privileged position in society

provided no privileged political/medical knowledge of the internal/hidden world of the political/human 'organism'.(87)

The above interpretation is the Rankin thesis that:

"the acceptance of homeopathy depended on the concealment of the operation of social interest. Rather the social interests of each group let them see the world in a way which was compatible with the furthering of those interests ..... Much more was at stake than a theoretical approach to therapeutics.... a whole structure of political and social ideology was being debated and that the failure to gain acceptance for that ideology would mean the loss of social and political power and prestige".(88)

Whatever the methodological merits, or otherwise, of the sociological construction of abstracted analogies between an epistemology of political order, and its mapping with an epistemology of a medical order, one is still left confused as to whether the homeopaths were practising medicine but actually doing politics. Or vice versa! It seems to me that Rankin, besides not defining what she means by 'interests', commits an error similar to that of Margaret Pelling (1983) but from the sociologist's side of the methodological divide. Thus, it seems to me that the same criticism basically holds good.(89) Rankin still seems to operate within a positivist type of Marxism.

I mean this in the sense that although she tries to transcend the science/ideology polarity by implicitly employing a sectional interests/ideology polarity the former polarity is still operating but with interests as the bridge between them. Ideological/political interests can surreptitiously steal across this 'bridge' to shape 'scientific' knowledge in all sorts of subtle ways: ways which are unconscious or unknown to the social agent. The hope and role of the sociologist, à la Rankin, seems to be rather like that of a psycho-therapist. By unearthing the 'real' but unconscious motives and interests of the client the hope is that 'enlightenment' will come when they are faced with their repressed/suppressed interests. My own position is that 'science' and 'ideology' are not separate symbol systems but that all symbol systems, including scientific ones, have ideological aspects and functions to them. Thus:

"to treat a symbol system as <u>an</u> ideology is to study it <u>as</u> ideological".(90) (emphasis added)

The relative strengths of 'scientific' and 'ideological' aspects of a symbol system will depend upon (a) the internal 'maturity' of the 'science', and (b) its degree of institutional insulation from direct, conscious political/ ideological interests.

The whole science/ideology, sectional interests/ideology

polarity can be transcended if 'science' is treated in this way. The only remaining use for the sectional interests/ideology polarity is a decidedly political one. This would be the criticism of exploitation and domination by hegemonic sectional interests.(91) With this in mind we shall now look briefly at the general ideological response of the regular profession to homeopathy.

5.5.2 The Response of the Regular Practitioners: Contours of Deviantization

The regulars' anti-homeopathic campaign effectively deviantized them and is remarkable in the degree of solidarity of opinion it generated amongst themselves. It ranged from the impatient, intemperate hysteria of the Lancet, to the severe reproaches of the more 'gentlemanly' Provincial Medical and Surgical Association.

(i) The Lancet

Even though Quin's policy had been to keep a low-profile to avoid the opprobrium of the regulars it did not stop the Lancet making its intemperate and at times, hysterical contribution to the ideological persecution of homeopathy whether in its professional or lay versions. The earliest report on homeopathy by the Lancet was of a discussion at the Medico-Botanical Society meeting on Tuesday, 11th. of November 1834.(92) The discussion was on the use of cutaneous medication and Mr. G.T. Guthrie mentioned the possible

homeopathic use of acetate of strychnia in difficult cases of ulcerated larynx. His suggestion was based upon a recent case he had been dealing with using the acetate. Dr. Johnson condemned homeopathy as an inefficient system which only delayed patients in receiving 'proper' (i.e. regular) treatment. As to the endermic medicine discussed he thought it would never replace the 'ordinary mode' of giving medicine, because it -

"would not square with the interests of practitioners, who were remunerated in proportion to the quantity of medicine they could persuade their patients to swallow".[93] (emphasis added)

It seems from this that the regulars were quite aware of the economic threat which the small doses of homeopathic medicines would have on their livelihood.

It was not until the 28th. of March, 1835, that the 'Lancet' first mentioned Dr. Quin by name, in connection with a report of the claimed clinical refutation of homeopathy by the French clinician Gabriel Andral (1797-1876), at the request of the Academy of Medicine.[94] On the basis of Andral's findings the Academy pronounced Hahnemann a charlatan and homeopathy charlatanry. This was on the 17th. of March, 1835, and the request for a dispensary by the homeopaths, which had prompted the trials, was rejected. So by this time the opinion leaders of the continental

medical profession were being reported by the Lancet. The methodological and therapeutical criticisms the homeopaths mounted against Andral's claimed 'crucial experiment' was omitted from the (regular) medical press.

Gossip and rumour about homeopaths and homeopathy circulated as 'fact'. For example, the Lancet reported a stormy debate at the Academy of Medicine on the 27th. of January, 1835. One of its members assured the Academy that in conversation with a celebrated Berlin professor (unnamed, and a professor of what?) the opinion had been given by that professor that as regards homeopathic doctrine -

" 'There are only three homoeopathists in Berlin; one of them is a rogue, and the other two are ignorami'. "(95)

The Lancet's consistent editorial policy was determinedly set against the homeopaths. No reconciliation was possible. If homeopaths were prepared to return to the ranks of 'rational medicine' there must be -

"nothing less than the most unreserved renunciation of all the dogmas of homoeopathy, in name and deed...".(96)

Only total surrender, not concessions, were the terms the 'Lancet' advocated.

"If homoeopathists would enter our societies, they must become practitioners of rational medicine, and <u>openly and</u>

fully renounce their professional creed".[97] (emphasis added)

In other words, in order to receive the forgiveness of the regular profession, for holding to a medical heresy, a repentant homeopath must make a public confession of his homeopathic sins. Precisely the same confessional solution was offered by regulars in the United States. The same stigmatization of homeopathy occurred as writers to the Lancet clamoured for an exposé of homeopathy; a medical cosmology they considered to be -

"contrary to all human reason and experience"[98]

"a tissue of absurdities, offensive to commonsense and contrary to observation"[99]

"completely visionary" and "mere delusion"[100]

"a system of knavery and deception"[101]

However, some of the reports of lectures at medical societies showed that some practitioners were more temperate in their speech. Even though they did not accept homeopathic claims they were prepared to discuss it in a gentlemanly fashion. For example, there were Dr. George G. Sigmond's lectures on 'Materia Medica and Therapeutics', at the Windmill Street School of Medicine, between 1836-37. In his first lecture he proposed the existence of two therapeutic systems which could be carried to extremes. First, the 'try-it-and-see' overdosing system of regular

(i.e. heroic) therapeutics. Second, the underdosing system of the homeopaths. The one saving feature of the latter system he admitted was its capacity to restrain:

"the love of giving inordinate doses of the most virulent poisons".(102)

He was even honest enough to admit that he remained a member of a profession which had a method of therapeutic practice he believed was -

"infinitely more dangerous than the other system, bad as it is, of giving infinitesimal doses".(103)

The appeals by homeopaths that the regulars test their therapeutic claims by practical means were ignored. Indeed, two years after the B.H.S. was founded, the Lancet declared that -

"The profession is not bound to walk out of its legitimate path to examine.... the claims and dogmas of any dupe or knave who chooses to shout, Eureka.....

We have past experience, the experience of four thousand years, which the experience of the next four thousand years is not likely to contradict, to show us that all mere systems of medicine have been erroneous. So it has been with countless systems of old, and so it is, or must be, with those of modern times.... Brunonianism, Broussaism, Perkinism, Hahnemannism, Mesmerism, Priessnitzism.... 'Young Physic',

or any other 'ic' or 'ism' that shall be hereafter.... .... Louis is the model that should be looked for in the young physician".[104] [The 'Louis' in the foregoing, was Pierre Charles Alexander Louis (1787-1872), the founder of medical statistics. c.f. section 3.5.1 (i) Numerical Method].

Surely it hardly needs pointing out that the above position is, in no way, an impartial and disinterested view of the history of medicine up until the mid-nineteenth century. Quite a number of those stigmatized as mere 'systems' would have to be regarded as the direct ancestors of heroic medicine, which was certainly 'orthodoxy' up to the 1840's.

The editor even provided a definition of a 'quack'. Unfortunately it did not fit the professional homeopaths. He said that the difference between a 'true physician' and a 'quack' was that the former was learned whilst the latter pretended to be learned. The 'quack', he claimed, in fact disdained learning.[105] Certainly something the professional homeopaths did not do.

Regular practitioners who were too generous to the homeopaths, in the Lancet's estimation, were chastized for undermining faith in regular medicine.[106] Thus, John Forbes (1787-1861) was severely criticised when he argued that, since the central curative principle of scientific medicine was the 'vis medicatrix naturae', it was best if

heroic intervention was not practised. He further argued that homeopathy actually cured because it unwittingly operated according to that same principle. The homeopaths mistakenly thought it was their infinitesimal remedies which cured.(107) The conclusion was mistakenly drawn by many that Forbes was arguing it was far better to use homeopathic remedies than practice regular heroic/neo-vigorous medicine.

The discontinuation of the journal, in which Forbes' rather lucid article appeared, was not unconnected with -

"the offence taken by the profession at his article (January 1846) entitled 'Homoeopathy, Allopathy and 'Young Physic' ". This article was probably misunderstood, and the outcry swelled by writers who had been personally aggrieved by other articles in the 'Review'."(108)
Forbes had not only been the editor of the 'British and Foreign Medical Review' which had published the article but he had personally lost about £500 in its production. His love of fairness was judged by the more intemperate, who wanted to see the issues between homeopathy and orthodoxy in black and white terms, as having carried him too far in approving what only homeopaths accepted. The Lancet concluded that those like Forbes only fell in with the aristocracy's support of homeopathic 'quackery', thus corrupting the profession. It saw the true purpose of

'Young Physic' as being to create -

"an orthodox spirit in the place of the prevalent Lapsarianism of the day".(109)

The Lancet thought it discerned two kinds of homeopathist. First, the "vagrant eclectics"(110) who used infinitesimal doses, (or globules) for easy diseases and bleeding for the difficult ones. Second, the pure "globulists"(111) who gave infinitesimal doses exclusively. It did not seem to matter that the 'little dose school' of homeopathy was not based upon dilutions but upon the principle of the 'similia'.(112) However, such accuracies seem to be the first victims under conditions of ideological conflict. Indeed, it seems that ignorance, error, gossip and all other forms of misinformation become the order of the day in the heat of ideological exchanges.

The medical press gathered, filtered and distributed such opinions about homeopathy rather readily and they were soon repeated along local practitioner social networks. The Noelle-Neuman thesis of opinion formation assumes that people seek to overcome, or avoid, social and psychological isolation. In the expression of their opinions they seek to identify, then follow, what seems to be the majority opinion, or 'consensus'. One of the main sources of information about the 'consensus' regarding homeopathy was the available media. In effect the medical press were

opinion-formers and reinforcers. They had some power to define what the prevailing 'climate of opinion' at a given time, or over a certain issue is, or ought to be. The more dominant a particular view of homeopathy was in the media and local dissemination networks the less contrary voices were taken notice of and the more silent they became.(113) In fact, one of the complaints the homeopaths made to the medical press, to no avail, was that they were denied the right of reply to unjust articles or letters. However, I certainly did not come across any articles by regulars, critical of homeopathy, included in the B.J.H. Although such articles and books were critically reviwed by the Journal, it is not quite the same thing.

It may be argued that the Lancet was atypical of the view of the majority of regular practitioners. This position cannot be sustained in the face of the rather more moderate and gentlemanly 'amateur scientific' style of the Provincial Medical and Surgical Association.

(ii) <u>The Provincial Medical and Surgical Association / British Medical Association</u>

1832 was not only the time of the great Reform Bill but also of the founding of the Provincial Medical and Surgical Association (abbreviated to P.M.S.A. henceforth) by Charles Hastings (1794-1866). He was formerly house surgeon 1812-15) and then chief physician (1818-62) at the

Worcester Infirmary. He had founded a quarterly provincial journal in 1828 called 'The Midland Medical and Surgical Reporter and Topographical and Statistical Journal' but that was superceded by the 'Transactions of the Provincial Medical and Surgical Association'. The aims of the P.M.S.A. were, firstly -

"the diffusion and increase of medical knowledge in every department of science and practice".(114)

Secondly, to maintain the honour and respectability of the profession generally by promoting friendly communication amongst its members in order to establish the harmony and fellow feeling which it considered should characterise a liberal profession.(115) Thirdly, to do its part in solving "the evils of quackery".(116) However, in regard to quackery the P.M.S.A. reported that

"All active measures in relation to the suppression of quackery had better be delayed in the hope that a better organization of the profession may render the suppression of quackery a more practicable undertaking than appears at present to be".(117)

Not only did the organizational interests of the corporations operate against united action being taken against quackery, especially patent medicines, but the economic interests of the government operated against it too. This was because it collected considerable stamp duty on

the patent medicines. Therefore, the P.M.S.A. initially accomplished little against what it saw as the general problem of unlicensed and unorthodox medical practice.

The position of the P.M.S.A. in relation to homeopathy became more definite as it entered into the task of parliamentary lobbying and representing the interests of provincial practitioners. Its style and tone were less intemperate than the Lancet but nonetheless it was clearly antipathetic towards them. In 1851 its 'Committee on Irregular Practice' saw several resolutions passed at their Brighton meeting of the 14th. of August. The resolutions passed were -

" 1. That it is the opinion of this association, that Homoeopathy, as proposed by Hahnemann and practised by his followers, is so utterly opposed to science and common sense, as well as so completely at variance with the experience of the medical profession, that it ought to be in no way or degree practised or countenanced by any regularly educated practitioner.

2. That Homoeopathic practitioners, through the press, the platform, and the pulpit, have endeavoured to heap contempt upon the practice of medicine and surgery, as followed by members of this profession, and by the profession at large.

3. That, for these reasons, it is derogatory to the honour of members of this association to hold any kind of professional intercourse with Homoeopathic practitioners.

4. That there are three classes of practitioners who ought not to be members of this association, namely: first, real Homoeopathic practitioners; second, those who practise Homoeopathy in combination with other systems of treatment; and third, those who, under various pretences, meet in consultation, or hold professional intercourse with those who practise Homoeopathy.

5. That a committee of seven be appointed to frame laws in accordance with this resolution, to be submitted to the next annual meeting of the association.

6. That the thanks of the association are eminently due, and are hereby given to the Presidents and Fellows of the Royal College of Physicians and Surgeons of Edinburgh, for their determined stand against Homoeopathic delusions and impostures.

7. That the thanks of the association are also due, and are hereby given, the Universities of Edinburgh and St. Andrews for their resolution to refuse their diplomas to practitioners of Homoeopathy; but the association feels imperatively called on to express

its disapproval of any school of medicine which retains among its teachers any one who holds Homoeopathic doctrines.

8. That these resolutions be printed and transmitted to all the medical licensing bodies and medical schools in the United Kingdom; and that they likewise be inserted in the 'Times' newspaper, the 'Morning Post', the 'North British Advertiser', 'Saunder's Newsletter', all the British and Irish medical periodicals, and such other journals as the Council may sanction, upon the recommendation of the branch association".(118) (emphasis added)

I will comment briefly upon the P.M.S.A.'s resolutions. The first resolution is a basically unsubstantiated claim whose origin is ideological not experimental. This was qualified by the homeopathist J.J. Russell, to the effect that although the curative effects of homeopathic doses may have been beyond the experience of the profession it certainly was not contrary to it.(119) Second, that over enthusiastic lay supporters, like Rev. Thomas R. Everest, may have made some foolish remarks but the professional homeopaths had certainly not made them. In addition, surgery had not been condemned by homeopaths because, as a craft, it had to be agnostic as far as claims for homeopathic therapeutics were concerned. Third,

resolutions three and four were a statement and elaboration of non-consultation. The comments already made about the A.M.A. consultation clause of 1847 hold here too. (see chapter 4 section 4.3.3) Fourth, the defining of the boundaries between the rather socially insecure, but upwardly aspiring, constituancy of provincial, general practitioners within the P.M.S.A., were drawn with the appointment of the 'anti-homeopathic/quack' committee. This would enable a united, ethical(?) campaign against them to be proposed later. Fifth, they ingratiated themselves with the corporations of physicians and surgeons, in Edinburgh. It is more than probable that this was because (a) they sought a positive identification with an actual conflict already going on and (b) a significant number of their members were probably trained there. Sixth, they symbolically identified themselves with the regular profession as well as making their position clear to the public. After all, it was 'the public' who patronized the homeopaths and they had to be convinced it was 'irrational' to go to practitioners who were considered 'quacks' by the authoritative fiat of the 'orthodox' profession.

It is noteworthy that although the anti-homeopathic ideologues could be rather excessive in their stigmatizations, they never reached the impassioned heights of their American brethren. Some of them made apocalyptic

pronouncements of the imminent end of the social order if homeopathy was permitted to flourish. But this has to be seen in the context of the impassioned rhetoric of all American public discourse at the time.(120)

In conclusion, it is clear that any idea of the Lancet's vituperations being atypical of the regular profession is contradicted by the evidence provided above. It is also worth remarking that the intellectual rigidity and dogmatism of the regulars towards the homeopaths was characteristic of the general style of the Victorian age.(121) Nor was it the prerogative of the regular profession only. Some of the early British homeopaths, professional and lay, had indeed been just as dogmatic about their own medical beliefs. This was a point not glossed over by the homeopathist, Mr. Alfred C. Pope, (Member of the Royal College of Surgeons, England) from York. He remarked in the B.J.H. for 1861:

"I fear that our opportunities of drawing the attention of allopathic practitioners to the investigation of homoeopathic therapeutics have been in some degree lessened by the mode in which we have received their attacks upon us and upon our system of treatment, and by in some instances withholding from them that courtesy to which, as members of the medical profession, they were entitled; owing doubtless to the assumption that their conduct towards us had deprived them of any of those claims to consideration

their professional relationship might otherwise have secured for them".[122]

However, if a judgement is to be made I would have to say that, on balance, the vituperative rhetoric originating from the regular profession, particularly the insecure provincial practitioners, puts into the shade any counter-criticisms and defensive labelling the professional homeopaths had done. This was probably because the professional homeopaths were 'heretics' rather than 'schismatics'. The difference being that although they each held beliefs at variance, or in antagonism with 'orthodoxy' the heretic continued to claim to be still part of 'orthodoxy'; maybe a 'truer' version of orthodoxy, even. The schismatic, on the other hand, deliberately seeks confrontation and division within orthodoxy, and separation from it. The (medical) heretic is prepared to accept that there are other ways of (medical) salvation. The schismatic does not hold such a position at all. The professional homeopaths did seek rapprochement after the Medical Act of 1858 defined them as within the 'charmed-circle' of professional eligibles designated as 'registered practitioners'.[123] However, we must ever bear in mind that the terms 'heretic' and 'schismatic' and so on carry much ideological work and many intellectual and emotional overtones from long historical practice.

(iii) A Note on the Henderson-Simpson Conflict in Edinburgh 1844-1853

1851 was not only the year in which the P.M.S.A. passed its anti-homeopathic resolutions but also the year that -

"the Royal College of Physicians and the Royal College of Surgeons, of Edinburgh, the Faculty of Physicians and Surgeons of Glasgow,..... and the Medical Society of London.... all severally passed resolutions prohibitory of their Fellows and members meeting professionally with those who affect to cure the diseases of patients with infinitesimal doses".(124)

This was part of a process begun in Edinburgh in 1844 when James Young Simpson (1811-70), Professor of Midwifery, wrote a book entitled "Homoeopathy: its tenets and tendencies, theoretical, theological and therapeutical"(125) William Henderson (1810-72) Professor of Pathology who had been experimenting with homeopathy since 1843 responded to this in a book entitled, "An Inquiry into the Homoeopathic Practice of Medicine" (1845). Their extended public conflict came to an end in 1853. In that year Simpson published a third edition of his 1844 book and Henderson responded with "Homoeopathy fairly represented: in reply to Dr. Simpson's 'Homoeopathy' misrepresented"(126) Simpson had very little new to add to his 1844 work and Henderson devoted his to providing

an outline of Hahnemann's life and medical work; comparing homeopathy and allopathy statistically; rebutting habitual criticisms; and describing basic Homeopathic beliefs about similia, provings and doses. Between 1844-53 others joined in the conflict, especially in 1851 when the corporations passed resolutions against homeopaths.(127) This failed to make Henderson leave the Royal College of Physicians (Edinburgh), of which he had been a fellow since 1838.(128)

Cliques of supporters developed in Edinburgh since the University was a rather fractious, sectarian place during the century. Simpson was soon joined by James Syme (1799-1870) and Robert Christison (1797-1882) when his 1844 book was published. Syme was Professor of Clinical Surgery and was of a rather "acrimonious disposition"(129) in pursuit of his own academic and professional interests.(130) Christison was Professor of Medicine (1822-32) and specialised in medical jurisprudence and toxicology. He was Professor of Materia Medica and Therapeutics (1832-77) at this time.(131)

The Henderson-Simpson conflict is important in that, in large measure, it set the acrimonious and vituperative tone of the debates and relationships which followed it, in Scotland and the North of England in particular. It had its own unique aspects of course. For example, there were the 'theological' elements pointed out by Simpson.

This is not surprising given Scotland's religious history and the equally fractious nature of ecclesiastical debate in the Church of Scotland. Ideologically it contributes little to what has already been said since chapter 3. So I only indicate its historical relevance in an intensive and extended conflict which involved whole generations of medical professors and students. Yet through it all Henderson remained remarkably even tempered although he sometimes struggled not to descend to the level of exchange favoured by Simpson and Syme.(132)

5.6 Strategic Resistance to Attempted Suppression and Elimination: the Limits of Monopolization

In the exercise of their power the regular's anti-homeopathic ideology functioned as a legitimation of politically inept and certainly morally indefensible actions. At times the ends justified the means in their campaign against the professional homeopaths as market competitors.

During the mid-nineteenth century, in the transition from heroic to sceptical therapeutics, the regular profession was in deep cognitive and institutional crisis. Their plausibility was under increasing doubt internally and externally. Although by mid-century they had begun to reform many aspects of practice, especially in surgery and midwifery, therapeutics produced little positive knowledge. Indeed, therapeutics was torn between those who advocated the new patho-physiological approach of

clinical-hospital medicine and those who clung to the decaying heroic theories and practices.

Some regulars responded to this crisis of transition by pointing the critical finger at the unlicensed and unorthodox practitioners whom they accused of undermining the honour of the profession. Others such as John Forbes pointed to the 'fact' that properly 'scientific' medicine (i.e. 'Young Physic') had only arrived upon the medical scene quite recently.(133) Its effect was to question the validity of heroic therapeutics as a whole. The advantage of clinical scepticism was that it could limit the over-indulgent therapeutic interventionism of regular practitioners. 'Young Physic' could train the physician what not to do. Since homeopathy was a sceptical, expectant therapy masquerading as an active (but genteel) therapeutic system, no real progress in relationships with it could be expected until its actual principle of cure was admitted; not 'similia' but 'vis medicatrix naturae'. So argued Forbes in 1846.

Other regulars simply refused to accept homeopathy because its claims were against 'science', 'tradition' and 'experience' as the P.M.S.A. 1851 resolutions also claimed. Yet, they were authoritative symbols which the professional homeopaths also appealed to, in their attempts to resist the control and domination of the regular profession.

The events described in what follows are designed to make the very simple point that the monopolistic powers of the corporations were never totally effective. Indeed it is inherent in the conception of power used here, that subordinate groups are not entirely powerless. They are able to resist the strategies of the powerful and mobilize their own power resources in that attempt. In one of the events described the homeopaths were able to prevent the suppression and exclusion of their cholera returns from the 1855 government report on the 1853-54 epidemic. In the second event they successfully resisted and turned to their own advantage, the attempt by regulars to cognitively and institutionally eliminate them by means of certain punitive clauses in the 1858 Medical Bill. To these events we will now turn our attention.

5.6.1 The 1853-54 Cholera Epidemic: An Attempt to Suppress 'Deviant' Medical Knowledge

Britain experienced several cholera epidemics in the first half of the century which prompted the establishing of a General Board of Health through the Public Health Act of 1848. The Act was -

"an uneasy compromise between those - mostly medical men and administrative experts - who favoured an element of compulsion and those who believed that disease was a local responsibility".(134)

The Board (abbreviated to G.B.H. henceforth) tackled the problems confronting it with determination but it became steadily unpopular as it advocated the administrative oversight of sewage, drainage, water supply and street cleaning activities. Edwin Chadwick (1800-1890) and Dr. T. Southwood-Smith (1788-1861) were the main dynamic behind the proposed sanitary changes. However, their apparently intolerant and abrasive manners had turned many people against them in the local authorities.(135) Chadwick was dismissed in 1854 and the Board wound up in 1858. In between that period Sir Benjamin Hall (1802-67) was appointed as its President. He had been one of the critics of the Board during Chadwick's time there.

(i) The Object of the 1855 Cholera Report

The outbreak of cholera in 1853-54 prompted Hall to choose a Medical Council whose main aim was to gather 'scientific' information upon the conditions which made for the spread of cholera; provide advice regarding the mitigation or prevention of the epidemic; and obtain the necessary information from all qualified practitioners as to the effects of various therapies and regimens. On the basis of such evidence it was to make recommendations regarding future improvements in public health and medical practices. It was from such evidence that the positive correlation between cholera and insanitary water supplies

was clearly demonstrated by John Snow (1813-58). Indeed, his statistical investigation has been celebrated as one of the most important epidemiological investigations ever undertaken in the public health field.(136) Be that as it may, such celebration has consistently omitted to take up the issue of the Treatment Committee's attempt to suppress the homeopathic returns from the Cholera Report of 1855. Even a recent study by A. Lilienfeld,(1982),of the development of medical statistics from clinical trials, comments on the 1855 Cholera Report that -

"The members of the treatment committee were also concerned about the question of dosages of the different medications but did not have adequate information by which to evaluate this".(137) (emphasis added)

It will be seen from the statistical tables given later that, (a) the Report itself presented,statistically speaking, inadequate information, in that some of the calculations were admitted to be averages from a small number of cases, and (b) that some information about the 'question of dosages of different medications' was available, but it came from a source assumed to be 'poisoned' by the members of the Treatment Committee. The fact of Lilienfeld's omission, of the significance of the homeopathic returns, in the appendices of the 1855 Report, is puzzling to say the least.

(ii) The Committees

The Medical Council of the G.B.H. was divided into three investigating committees. The Committee for Scientific Inquiries was made up of William Farr (1807-1883), a statistician at the Registrar General's Office and ex-student of Louis, the so-called father of the numerical method of analysis in medical statistics. Farr was an honorary M.D., a distinction he had received from New York in 1847. Then there were Dr. Neil Arnott (1788-1874), M.R.C.P. (London), physician extraordinary to the Queen, natural philosopher, inventor and Fellow of the Royal Society (abbreviated to F.R.S. henceforth); Dr. William Baley, F.R.S., assistant physician to St. Bartholomew's Hospital and physician to Millbank Prison; Mr. Richard Owen (1804-92), F.R.S., Professor of Zoology at the Royal College of Surgeons (London), conservator of the Hunterian Museum and a well known anatomist in Britain and on the Continent. Lastly, Mr. John Simon, F.R.S., surgeon to St. Thomas' Hospital and officer of health to the City of London.

The Committee for Foreign Correspondence included Dr. Benjamin Guy Babington (1794-1866), F.R.S., F.R.C.P. (London) and lately physician at Guy's Hospital, Dr. John Bacot, inspector of anatomy and a member of the London University Senate; Sir James Clark (1788-1870) M.D., F.R.S., physician-in-ordinary to the Queen and H.R.H.

Prince Albert; Mr. William Laurence (1783-1867), vice-president of the Royal College of Surgeons (London), F.R.S., surgeon to St. Bartholomew's Hospital and surgeon extraordinary to the Queen.

The Treatment Committee consisted of its chairman, Dr. John Ayrton Paris (1785-1856), F.R.S., president of the Royal College of Physicians (London); Dr. Benjamin Guy Babington (also on the previous committee); Dr. James Alderson, treasurer and F.R.C.P. (London), F.R.S. and physician to St. Mary's Hospital; Dr. Alexander Tweedie (1794-1881) F.R.C.P. (London), F.R.S., physician to the London Fever Hospital, the Foundling Hospital, the Standard Assurance Co., and examiner in medicine at the University of London. He had co-authored with C. Gaslee a work appropriately called 'A Practical Treatise on Cholera' (1832). Finally, there was Mr. Nathaniel Bagshaw Ward (1791-1868), botanist and Master of the Society of Apothecaries. Ward was also a founder of the (later 'Royal') Microscopical Society in 1839.[138] It is this committee which will take our attention in what follows.

(iii) The Treatment Committee: its Purpose and Findings

This committee's purpose was to distribute and analyse the returns from metropolitan and non-metropolitan hospitals, regarding cholera treatments used and their relative

effectiveness. There was found to be little difference between the recovery/mortality ratios of metropolitan hospitals and districts, and non-metropolitan districts. The use of the 'numerical method' was in order to clear away -

"valueless modes of treatment" and to commence "a system of medical statistics - a system which is intended to produce not opinions, but materials on which philosophical deductions are hereafter to be based".(139)

The returns were classified into four modes of treatment - alteratives, astringents, stimulants and eliminants. Alterative therapies included large or small doses of calomel, calomel with opium, mercurial preparations, and salines. These were sometimes used in conjunction with hot-air baths, bleeding, opium, internal or external stimulants, chalk and opium, or an aperient.(140)

Astringent therapies included sulphuric acid, other mineral acids such as nitric, nitrous and nitro-muriatic, chalk mixture, chalk and opium, acetate of lead and opium, and opium. These may have been used in conjunction with internal and external stimulants, hot-air baths, calomel, opium, an emetic, or opium by glyster.(141)

Stimulants included ammonia, ether, brandy and chloroform and may have been combined with emetics, opium, wine, calomel, hot-air baths and hot-water baths.(142)

The eliminant therapy was castor oil which may have been combined with external stimulants, ice water, and bleeding.[143] Below are tables variously analysing the returns and taken from the appropriate reports.

Table (1) This compares the modes of treatment in terms of specific therapies relative to the total number of recorded deaths under those treatments.[144]

Treatment Mode	Therapy	% Mortality
Alteratives	Calomel & opium	30.9
	Calomel in lg. doses	47.4
	Other mercurial therapies	55.3
	Salines	75.0
	Calomel in sml. doses	80.4
Astringents	Mineral acids (not sulphuric)	40.7
	Chalk mixture & chalk with opium	45.2
	Opium	50.0
	Sulphuric acid	65.4
	Acetate of lead & opium	76.1
Stimulants	Ether	33.6
	Ammonia	75.6
	Brandy	76.9
Eliminants	Castor oil	66.6

Table (2) Comparison of the number of collapse cases ending in death, relative to different therapies.[145]

Treatment Mode	Therapy	% Mortality
Alteratives	Calomel & Opium	45.2
	Calomel in lg. doses	54.1
	Other mercurials	66.6
	Calomel	100.0
	Salines	100.0

Table (2) continued

Treatment Mode	Therapy	% Mortality
Astringents	Mineral acids (not sulphuric)	52.3
	Chalk mixture & chalk with opium	79.1
	Sulphuric acid	80.1
	Opium	85.7
	Acetate of lead & opium	100.0
Stimulants	Ammonia	90.0
	Ether	93.0
	Brandy	100.0
Eliminants	Castor oil	83.3

Table (3) The order of efficacy of the different remedies in comparison with total number of cases with death as a result.(146)

Therapy	% of deaths in total cases
Gallic acid and other astringents†	26.3
Chalk mixture and chalk with opium	27.3
Opium†	30.5
Calomel and opium	35.8
Mineral acids (not sulphuric)†	40.7
Ether*	42.2
External and Internal stimulants	45.0
Calomel in lg. doses	46.0
Alum and iron preparations†	46.1
Sulphuric acid	
Chloroform†	48.3
Calomel in sml. doses	49.4
Salines	50.5
Other mercurial remedies†	52.5
Ammonia	61.4
Acetate of lead and opium†	61.7
Brandy	63.0
Castor oil	69.3
Emetics	80.9

Key * In a large number of cases, opium was given with ether.

† Averages from a small number of cases.

Table (4) The order of efficacy of different therapies in comparison with collapse cases ending in death.(147)

Therapy	% of deaths in collapse cases
Mineral acids (not sulphuric)†	52.3
Gallic acid and other astringents†	55.5
Calomel and opium	57.2
Calomel in lg. doses	59.2
External and Internal stimulants	62.5
Chloroform†	65.2
Chalk mixture and chalk with opium	67.0
Salines	67.0
Other mercurial therapies†	71.1
Opium	73.3
Calomel in sml. doses	75.7
Sulphuric acid	76.5
Acetate of lead and opium	76.9
Castor oil	77.6
Ammonia	77.6
Brandy	80.5
Emetics	80.9
Alum and iron preparations	85.7
Ether	89.0

Key † Averages from a small number of cases.

Table (5) Percentage of deaths in all cases under the four modes of treatment, averaged out and compared in terms of the number of deaths in metropolitan, and metropolitan plus provincial figures.(148)

Treatment Mode	% of deaths in all cases	
	Metropolitan	Metropolitan & Provincial
Eliminants	71.7	76.0
Stimulants	54.0	52.3
Alteratives (calomel and opium)	36.2	35.8
Astringents (chalk and opium)	20.3	27.3

Table (6) Comparison of the efficacy of certain therapies in terms of death in metropolitan and metropolitan plus provincial figures, in collapse cases.(149)

Therapy	% deaths in collapse cases	
	Metropolitan	Metropolitan & Provincial
Calomel and opium	59.2	57.2
Calomel in lg. doses	60.9	59.2
Salines	62.9	67.0
Chalk and opium	63.2	67.0
Calomel in sml. doses	73.9	75.7
Castor oil	77.6	77.6
Sulphuric acid	78.9	76.5

The Treatment Committee then concluded that -

"The evidence of these tables condemns the eliminant treatment altogether as a principle of practice.

It testifies against the stimulant principle, excepting as a resource in extreme cases.

It displays the decided advantage in the alterative principle, especially as carried out by calomel and opium; and it shows a still superior advantage in the astringent principle as applied through the means of chalk and opium - the general percentage of deaths following each plan of treatment being,

of Eliminants		71.7%
Stimulants		54.0%
Alteratives	(calomel & opium)	36.2%
Astringents	(chalk & opium)	20.3% ".(150)

The metropolitan figures were based upon 1,104 cases in metropolitan hospitals and 1,645 in metropolitan districts.(151)

(iv) Fighting Back: the Returns of the London Homoeopathic Hospital

The homeopath's hospital was situated at Golden Square, St. James', Westminster. This was admitted by the Scientific Committee of the G.B.H. to be where the cholera epidemic was at its most intense and destructive.(152) The health inspector for that parish was Mr. Patterson, but he refused to inspect the type of cholera cases being treated at the London Homoeopathic Hospital (abbreviated to L.H.H. henceforth). Therefore the L.H.H. management committee invited Dr. MacLoughlin to inspect their situation. He was the inspector responsible for Stepney and Poplar Union, St. Andrews (Holborn), St. Giles and St. George (Bloomsbury) and confirmed that they were treating true cholera cases.

The L.H.H. returns were forwarded to the Board about September of 1854. The various committee reports began to appear early the following year and the homeopaths at the L.H.H. immediately noticed that their returns were omitted from the statistics and conclusions of the Treatment Committee's report. Awareness of the omission occurred sometime between the 22nd. of February and the 20th. of April 1855. This was between the time when Dr. MacLoughlin sent a

letter to Mr. Hugh Cameron, a surgeon at the L.H.H., and when Mr. Ralph Buchan, honorary secretary to the L.H.H. lay management committee, wrote to the President of the Board requesting an explanation of such an omission from their reports.(153) It was Quin who had recommended at a meeting of the L.H.H's cholera committee, on the 3rd. of April, that the lay management committee be the ones to take up the matter with Sir Benjamin Hall.(154) A few days before the L.H.H. cholera committee met, Quin had published a report commenting that in his estimation the best 'allopathic' treatment was calomel and opium but it had an average mortality, he estimated, of 60%. The average for all treatments he calculated at 77%.(155)

A summary of the homeopathic results were provided in the letter of Mr. Buchan to Sir Benjamin Hall, of 20th. of April, as follows:

Table (7) Summary of the L.H.H. returns on cholera treatment.(156)

Cholera treated	A	B	C	D	E	F
As in-patients	33	23	5	25	7	1
By visiting staff	18	13	3	13	3	2
Out-patients	10	-	-	10	-	-
Total	61	36	8	48	10	3

Key A = cases admitted B = Collapse cases
C = Consecutive Fever D = Recovered
E = Died F = Discontinued

Diarrhoea treated	G	H	I	J	K	L
In-patients (choleraic)	5	-	-	5	-	-
Visiting Staff (")	5	-	-	5	-	-
Out-patients - choleraic	116	4	2	107	1	2
- simple	205	1	-	201	-	3
	331	5	2	318	1	5

Key G = Number of cases H = Passed into Cholera
I = Discontinued J = Recovered
K = Died L = Unknown

Buchan's letter to Hall also pointed out the fact that their mortality, using homeopathic treatment, was only 16.4%.(157) This was underlined by the mention of Dr. MacLoughlin's letter of 22nd. of February, in which he had said -

"that all I saw were true cases of cholera, in the various stages of the disease, and that I saw several cases which did well under your treatment, which I have no hesitation in saying would have sunk under any other".(158)

MacLoughlin concluded by offering the comment that -

"was it the will of Providence to afflict me with Cholera, and to deprive me of the power of prescribing for myself, I would rather be in the hands of a Homoeopathic than an Allopathic adviser".(159)

High praise indeed from an anti-homeopathic, regular physician.

Mr. J.F. Campbell, assistant secretary for the G.B.H. entered into correspondence with Mr. Buchan. It was pointed out to Campbell that because of the omission of their returns the 'scientific' value of the report was seriously compromised. As to the difficulties which could be caused by the patrons of the homeopaths, Campbell was left in no doubt, for Buchan attached a list of patrons to his letter. Patrons such as the Duchess of Cambridge, Archbishop Whately of Dublin, Lord Robert Grosvenor M.P. and various other aristocrats, politicians and military people.(160) Many were absentee patrons but the obvious intention was to indicate the authoritative social and political resources which could be mobilized if justice was not seen to be done.

Campbell wrote to Paris, the Treatment Committee Chairman, on the 20th. of April, and asked for an explanation of the exclusion of the L.H.H. returns from their deliberations. Paris replied, on the 21st. of April by quoting a resolution, passed unanimously by the committee:

"Resolved, That by introducing the returns of homoeopathic practitioners, they would not only compromise the value and utility of their averages of cure, as deduced from the operation of known remedies, but they would give an unjustifiable sanction to an empirical practice alike opposed to the maintenance of truth, and to the progress of science".(161)

Although Paris had a well known antipathy for anything homeopathic the documentary evidence does not include any record that it was he who proposed, or even seconded, the resolution. The least which can be said is that he certainly would not have opposed it. To have included the homeopathic returns would have shown how ineffective the regular therapies were by comparison. The apparent 'neutrality' of a government investigation could be 'used' by the regulars to promote their own goods and services as effective against cholera. Thus, the homeopathic results had to be excluded not only on theoretical grounds but also those of livelihood. Their incorporation in a government report may also have given them a legitimacy the regulars wanted to avoid. The implication that the homeopaths used unknown remedies was false because they could all be found in Paris' own book on therapeutics, 'Pharmacologia' (1812, with a 9th. edition in 1843). It was homeopathic theory and practice which was being stigmatized, not its therapies qua therapies. It seems that in the context of the rhetoric of 'useful science', which they, as fellows of the Royal Society, probably supported and promoted,(162) homeopathy was classed as useless pseudo-science.

Having raised the matter of the missing returns with the G.B.H., it was Lord Robert Grosvenor (M.P.) who raised the matter in the Commons on the 14th. of May, 1855.(163)

By the 17th. of May a request was made for copies of any letters to the Board complaining of the said omission from the reports and any correspondence between the Board's President and the Medical Council.(164) The ensuing embarrassment to the Government, but especially the President of the Board, was sufficient to have the returns included in an appendix to the 1855 Cholera Report. Even politicians not particularly favourable towards homeopathy were outraged at the immorality and injustice of the Treatment Committee's actions. It was reported at the time that some were -

"so disgusted with the attempt of the Treatment Committee of the Board of Health to suppress our returns that they would vote in favour of any movement to place the homeopaths in a fair position.(165)

The Lancet's comment upon the proceedings was, predictably, to support Paris and the committee's resolution to exclude the homeopathic returns. It said that since -

"The Medical Council was entrusted with the task of analysing the results of different methods of treating cholera; it had to weigh the value of various therapeutic means. What has homoeopathy to do with therapeutics?"(166)

Obviously, nothing, in the Lancet's estimation. Such a staggering blindness to the 'superiority' of homeopathic treatment of cholera over even the best regular therapies,

and the dubious nature of professional morality which justified such injustice to itself, was a clear function of anti-homeopathic ideology shaping the perceptions, morality and actions of the regulars.

(v) Conclusion

It is quite clear, that although the regular profession was dominant within the structured asymmetries of occupational power they were not totally dominant. Their antipathy towards homeopathy may have legitimated purely Machiavellian motives to exclude homeopathic knowledge from the 1855 Cholera Report (i.e. pursuit of professional purity) but they had not reckoned with the homeopaths' ability to mobilize their own authoritative resources in Parliament. It was enough to shame the government into instructing the Board to publish the returns in the final report - as an appendix. That may be interpreted as still something of a symbolic exclusion from 'legitimate' medical knowledge. However, it was still an important moral victory for the professional homeopaths over a profession whose members were willing and able to stoop to the falsification of official statistics in order to combat them as a medical system.

5.6.2 The 1858 Medical Act and After: the Legislative Inclusion and Socio-Cognitive Exclusion of Professional Homeopaths From the Regular Profession

The nineteenth century medical reform movement achieved a

significant landmark, between the competing interests within the medical profession, in the 1858 Medical Act. The Act itself was a typical piece of Victorian compromise, attempting to create something new whilst preserving the old as much as possible. In this case the 'something new' was the General Medical Council, and the 'something old' was the twenty-one licensing bodies.(167) As we have seen it provided the basis for increased unification of the regular profession; equality before the law of all certificated and registered practitioners; the monopolisation of all government medical posts; and a precise boundary between qualified and unqualified practitioners. It improved the status of apothecaries and surgeons without lowering that of the physicians, who now became an elite within a single occupation of professional medicine. However,

"Parliament's failure to grant licensed medical men a monopoly over the practice of medicine and the care of the sick suggests that, beneath the issues of patients' liberties and laissez-faire, legislators put little faith in scientific expertise and in the medical license as proof of that expertise. Medical men themselves seemed to see the issues more in terms of protection from competition than in terms of the superior claims of medical science".(168) (emphasis added)

However, I would want to add that the attempts by regulars

to have legislation enacted which was in favour of 'regular' practice only, would have allowed them to prosecute and persecute anyone (regular or not) who practised 'unorthodox' medicine, was also formulated in terms of arguments about 'scientific medicine', as well as legislative fiat regarding the cognitive boundaries between 'orthodoxy' and 'heresy'.

The demand for a single register was not favoured by the Royal College of Physicians (London) at all. They saw it as a means of lowering their status in the existing hierarchy of estates and corporations. The demand came mainly from the upwardly mobile provincial practitioners who framed their arguments for it in terms of an anti-monopolistic, laissez-faire ideology. However, such an ideology was quickly suspended as the estates and corporations operated against the homeopaths and proposed legislation which would exclude them from governmental recognition and give legal warrant to existing attempts to suppress and eliminate them from the face of professional medicine. The celebration of the importance of the 1858 Medical Act, in the development of a unified medical profession, by historians and sociologists of medicine(169) completely misses the fact that it was the intervention of the homeopaths and some strategic supporters which resulted in an Act that allowed 'registered practitioners' the liberty of practising a system of medicine, or

surgery, according to their conscience and within the law of the land.

Royal Assent was given to "An Act to Regulate the Qualifications of Practitioners of Medicine and Surgery" on Monday, the 2nd. of August, 1858. However, it needs remembering that it was largely based upon the Medical Bill of 1852. In its original form, that Bill would have criminalized the practice of homeopathy, or any other non-regular practice of medicine and surgery. This would have given the corporations completely new and autocratic power against all irregular practitioners, no matter how well qualified they were. This was a point which was not lost on the professional homeopaths as they reviewed the results of the Act and the situation prior to its enactment:

"Anyone who will peruse the original draft composed by an obscure clique of conspirators, will at once perceive that one of the main objects of the legislative scheme there disclosed was to extinguish completely and forever the homoeopathic heresy".(170)

In the original draft of the Bill, the means to strike 'irregular' practitioners from the register was to be the complaint and testimony of three registered, 'regular' practitioners. They were to make the complaint to their respective corporation's governing council and, if

substantiated, the appropriate council would delete the name of the offender from its roll. They would then inform the central registering authority which would strike the name from their register. No right of appeal against corporation decisions was provided for. The effect would have been to create a series of corporation 'star chambers' with the fear of gossip about 'irregular practices' enforcing professional conformity. In short, the regular profession would have to use sectarian methods of thought and behavioural control in order to attain and maintain occupational and cognitive purity/conformity. This is another indication of the depth of the reaction evoked by the 'deviant' homeopaths.

Political sympathy for the professional homeopaths may have come from the fairly recent episode of the suppressed cholera returns, only three years previously. However, there had been a more recent incident of injustice which probably contributed more to the later successful amendments to the Bill. This was the attempt, by the University of Aberdeen, to prevent Mr. C.T. Harvey, M.R.C.S. (England), from qualifying as a doctor of medicine because he was practising homeopathy.(171) The medical faculty at Marischal College refused to examine Harvey until he had written to say that -

"as a man of honour, <u>you have not practised</u>, and <u>do not</u>

entertain any intention of practising the profession on other principles than those taught and sanctioned in this and any other legally recognized schools of medicine. That homoeopathy or any other species of irregular unauthorised practice is what you entirely repudiate".[172] (emphasis in original text)

Mr. Harvey refused to comply and consequently was refused to be admitted to the rest of his examination; and thus denied his degree. The homeopaths were quick to point out that the purpose of medical institutions was -

"not to give a guarantee to the public that their licentiates profess a certain form of medical faith but merely that they are sufficiently educated men.... Such being the case they have no right to exact from a candidate an obligation to practise or refrain from practising according to any particular method.....

Moreover it should be remembered that faculties and schools of medicine have no fixed and immutable principles of medical practice to offer".[173]

They challenged the Faculty of Marischal College to state the principles of medicine they held to be those 'taught and sanctioned in this and any other legally recognized school(s) of medicine'. They, of course, were not forthcoming. Harvey consequently petitioned both Houses of Parliament describing how he had been treated by the

Marischal faculty of medicine and requested that a clause be introduced in the Medical Bill before Parliament to prevent such actions being taken by a licensing body. Petitions to that effect were gathered in Lancashire (Harvey practised at Blackpool) and presented by Lord Ebury (i.e. Lord Robert Grosvenor) to the House of Lords, and by the Hon. William Francis Cowper (1811-88), Palmerston's stepson, to the House of Commons. The Bill was about to go for its third and final reading, without amendments. Lord Grosvenor determined to frame an amendment to prevent the criminalization of professional homeopaths purely on the grounds of their therapeutic practices. Together with Mr. Cowper and a homeopathic practitioner, Dr. Robert Ellis Dudgeon (1820-1904), a new clause was framed and moved as an amendment to the Bill during its third reading in the House of Lords.(174) If it had been opposed it had been arranged that several peers would support its inclusion (e.g. Lord Lyndhurst). Apparently, J. Young Simpson, an arch opponent of homeopathy was in the Strangers Gallery to observe the reading, and he did nothing to generate any opposition to the Bill, or its amendment.

Having passed through the Lords with the amendment the Bill went to the Commons on the 29th. of July, 1858. There, Mr. Cowper drew attention to the amendment which he declared was for the express purpose of protecting the

homeopaths. He gave a brief account of the incident which had prompted such an amendment and the Bill received supporting commendation from Lord Elcho and Mr. Brady. It then passed through the Commons, with its amendments, unopposed and soon became law.(175)

This must have been a bitter blow to all those regulars who sought to include in their desire for medical reform, a crusade against the homeopaths. The comment of the B.J.H. upon it all was to say -

"The Act which they fondly and foolishly hoped would be for the suppression of homoeopathists, is in reality an Act for the protection of homoeopathists".(176)

For once the 'Medical Times' and 'Medical Circular' were silent about the consequences of the Act for the homeopaths. The clause which was added to the original bill, to protect the homeopaths was numbered XXlll and read as follows:

"Privy Council may prohibit Attempts to impose Restrictions as to any Theory of Medicine or Surgery by Bodies entitled to grant certificates.

XXlll. In case it shall appear to the General Council that an Attempt has been made by any Body, entitled under this Act to grant Qualifications, to impose upon any Candidate offering himself for Examination an Obligation

to adopt or refrain from adopting the Practice of any particular Theory of Medicine or Surgery as a Test or Condition of admitting him to Examination or of granting a Certificate, it shall be lawful for the said Council to represent the same to Her Majesty's most Honourable Privy Council, and the said Privy Council may thereupon issue an Injunction to such Body so acting, directing them to desist from such Practice; and in the event of their not complying therewith, then to order that such Body shall cease to have the power of conferring any Right to be registered under this Act so long as they shall continue such Practice".(177)

However, the Act certainly did not stop attempts by the regulars to continue to exclude homeopaths from various voluntary associations they had created for the purpose of assisting the registration of medical practitioners, regular practitioners that is. Thus, although the professional homeopaths, their patrons and parliamentary supporters, had won a great deal from the polity, the anti-homeopathic campaign continued. They had successfully resisted an attempt to legislate their elimination by the strategic mobilization of their own authoritative resources.

The means whereby the anti-homeopathic campaign continued was in their exclusion from the various voluntary medical associations. In fact, the regulars even created a new

kind of medical association to benefit themselves only. These were the "Medical Registration Societies". They also continued to create problems regarding consultation, at the British Medical Association branch meetings.

(i) The Medical Registration Societies

The General Medical Council found it virtually impossible to bring 'unqualified practitioners' to trial for assuming titles they had no legal right to.(178) The regulars responded to the ineffectiveness of the Medical Council by forming 'Medical Registration Societies'. These societies had two aims. First, to assist the registrar of the G.M.C. to secure a complete registration of all 'qualified practitioners'. Second, to protect the profession and public against illegal practices as defined by the Act. However, the societies limited their 'assistance' of the registrar to qualified regular practitioners only. The homeopaths took their exclusion from them and membership of them to mean that -

"Being on the register implies that your diplomas are in order; but belonging to the association implies not only that you have a diploma, but that you are untainted by heresy".(179)

The regulars, therefore, continued to exercise their ingenuity in devising new ways to maintain the barriers

of exclusion and professional purity now that the professional homeopaths had gained the technical legitimacy of being 'registered practitioners'. Such a technicality did not stop their continuous campaign against them since the 1830's. Yet not once had 'orthodox medicine' been defined and its principles stated. Its operation, as a concept and organizational symbol, functioned at the tacit level of professional identity generated by regular education and the professional culture of the corporations, universities, medical schools, voluntary associations (like the British Medical Association) and the medical press.

(ii) The Problem of Consultation

Although consultation with homeopaths was officially banned by the regular medical corporations and voluntary associations it did not prevent it from occurring altogether. Often it was on humanitarian grounds that some practitioners permitted it to themselves. There were also areas of common (non-therapeutic) practice, method and principles such as midwifery, surgery, most specialist treatments, diet, and case management. The homeopaths certainly saw these as positive areas for professional intercourse.(180) The opposition to consultation was thought by the homeopaths to be strongest from provincial practitioners rather than metropolitan ones. They argued that -

"The pressure of the majority is not generally so severely felt by the leaders of the metropolis, and we are happy to be able to testify to the honourable conduct of some of the most distinguished operating surgeons and specialists towards their homoeopathic colleagues, to whom they are ready to lend their valuable and valued aid on all occasions on which it is sought".(181)

whereas,

"in provincial towns at any rate, the operating surgeons, consulting physicians, and specialists, are dependent on the rank and file of the profession for their existence. They are, therefore, forced to truckle with the prejudice of those on whom they depend for their bread, and - often, we believe, against their better judgement - to practise that exclusion from intercourse with the homoeopathist which is a virtual imputation on his honesty and integrity. It is sad to think of the moral degredation to which they must submit, so far as they are conscious of what they are doing, when they refuse to lend assistance to their homoeopathic colleagues, and by such ostracism brand as infamous characters men whom they, perhaps, know to be their equals morally, intellectually and socially".(182)

After the 1858 Medical Act the professional homeopaths could argue a much stronger case for the unethical and unprofessional character of anti-homeopathic exclusion

clauses. In 1858 it was argued by one of their number that -

"The plain and simple rule is, that when a properly qualified medical man does nothing wrong or contrary to the rules of etiquette, no mere change of view as to scientific matters, ought to put any barrier between him and his colleagues. To beg the question and decree that change of scientific views is itself a breach of etiquette is, of course, for ever to place the progress of medical science at the mercy of the ignorant, prejudiced and jealous part of the profession, and is in the end as futile as it is wrong".(183)

This position was still being argued by the homeopaths in 1881 -

"The first principle to be laid down is that there can be no right to refuse absolutely to consult with any qualified medical man unless he has been cut off from the rights and privileges of the profession by any criminal or other conduct morally 'contra bonos mores', such as is generally brought before the Medical Council, and therefore to refuse to consult with him is tantamount to an accusation of infamous and immoral conduct".(184)

That the regulars continued to pass resolutions against consultation with them was something the homeopaths could not understand.(185) What they seemed unable to conceive

was that the regulars did not hold homeopathy to be a matter of 'science' at all. So they could honestly refuse to consult with those who, ideologically, were still 'heretics' and pseudo-scientific 'charlatans'. In addition such consultation could be refused in 'good faith' for bad reasons. Many regulars still believed that homeopaths were renegade members of the regular profession and were of two types -

"either he believes it, and is himself deluded; or he does not believe, and practises it for the sake of deluding others".(186)

The regulars, so the homeopaths reported, thought that if a person genuinely believed in homeopathy then their mental state and calibre was suspect, but since they thought there were few genuine believers in homeopathy, it followed that the many fell into their second category - deliberate confidence tricksters.

It is clear that the registered homeopaths sought assimilation into the regular profession, cognitively as well as socially, but not at the cost of giving up the 'similia' principle apparently -

"It is becoming evident to cultivated minds that medical practice is far from being in a satisfactory state, and that differences in the details of practice ought not to form a ground of professional estrangement".(187)

"We are ready to admit that in the past there have been faults of temper and errors of judgement on one side as on the other..... We earnestly desire reconciliation and reunion, but these can only come about by a frank recognition on the part of our brethren of the soundness of our principles..... You can only kill homoeopathy by recognizing it".(188) (emphasis added)

Therefore, the 1858 Medical Act provided legal equality for all 'registered practitioners'. The professional homeopaths were able to amend the Bill at its 'third reading' stage so that they (and future converts) would be defined as 'registered practitioners' and not be prevented from practising homeopathically. Yet, the ideological campaign persisted against them, as did official exclusion from voluntary medical organisations such as the British Medical Association. The homeopaths continued to seek for full acceptance through mutual forgiveness and reconciliation. They seemed oblivious of the fact that such rapprochement could only increasingly take place on terms set down by the regulars. In their quest for 'scientific' and full cognitive, professional 'legitimacy' they failed to see that the cost of such 'legitimacy' would be the loss of their own therapeutic distinctiveness. If they continued being cognitively distinctive then their deviantization would continue. Only if such 'deviance' was completely given up could

what they sought be attained. As long as the ideology of the regular profession remained as it was, full 'scientific' and professional recognition would be (and was) denied.

5.7 The Routinization of Debate

From the 1830's onwards the conflict between the regulars and 'heretical' homeopaths was intense as the heroic-bedside cosmology crumbled. This resulted from its own internal degeneration, the emergence of therapeutically sceptical clinical-hospital medicine, and the criticisms of the homeopaths (along with others, such as medical botanists, herbalists and hydropothists). However, quite early on in the polemical exchanges and criticisms the theoretical level of the debate became routinized and ritualized. Intellectual criticisms of homeopathic theory and practice were routinely refuted by the homeopaths, and the regulars criticised in the process. This pattern of criticism and counter-criticism, refutation and counter-refutation, habituated much of the dialogic exchanges. Since this dialogue proceeded within antagonistic anti-homeopathic and anti-allopathic ideologies, reciprocal cognitive defence systems turned many intellectual exchanges into cognitive and verbal rituals. In other words, reciprocally patterned sets of cognitive and verbal forms, conventions, customs or routines were constituted.

Routines sustain the taken-for-grantedness of everyday cognitions and actions. When internal and/or external threat begins to erode this security there are attempts to re-establish, or re-groove, previously accepted practices and thought forms. In short, there is a 'natural' conservative and defensive response. Part of the re-grooving and re-routinization response of regulars (and homeopaths) was to standardize verbal conflict into ritual, or fixed forms. An exemplary work, which exhibited such a ritual and paradigmatic routinization of dialogic conflict, was that published for the Irish Homoeopathic Society in 1848 and edited by Charles W. Luther. It was entitled, "A Concise View of the System of Homoeopathy, and Refutation of the Objections Commonly Brought Forward Against it".(189) Not only was it an exemplar of a ritualized cognitive exchange but also a paradigm of apologetic propaganda, pastoralia and evangelism. It was divided into two parts. First, a presentation of the history of Hahnemann and how he arrived at the doctrines of homeopathy, followed by detailed explication of the similia, homeopathic materia medica, dilutions, simplicity of medication, the homeopathic treatment of diseases and criticism of nine modes of regular therapeutics.(190) This first part takes up about 60% of the book. Second, a point by point refutation of twelve common objections to homeopathy, taking up 39% of the book. The remainder is given to detailed

statistical data on homeopathy as regards its hospitals and therapeutic achievements in Britain and Continental Europe. We shall be concerned with the second part of the book.

5.7.1 Routine Objections and their Refutation[191]

First, that small homeopathic doses cannot have any effect. The routine answer was that small doses were not the essence of homeopathy. The 'similia similibus curantur' was though. The use of small doses in high dilutions came well after Hahnemann and his disciples had been practising according to the similia. It was admitted that superficially it did appear incredible that small doses could have any therapeutic effect. Practical experience in their use was sufficient answer to such an objection. Neither was there much point in increasing their bulk as they worked perfectly well in their small size. Since there are numerous examples of small quantities of material agents (e.g. magnetism, electricity, vaccination) which affect the body in a powerful way, the smallness of the dose is no more irrational than the concept of the infinite divisibility of matter.[192]

Secondly, homeopathic medicines are powerful poisons and thus, dangerous. This objection is a flat contradiction of the first objection. With a few exceptions, homeopathy uses the same materia medica as the regulars and -

"if they are not dangerous in the large allopathic doses, is it not absurd to pronounce them such in the minute homoeopathic quantities?"(193)

Obviously the answer to that question was purely rhetorical.

Thirdly, that homeopathy used only one medicine for all diseases. Such an accusation was refuted by the fact that 240 medicines were listed in the homeopathic materia medica.(194)

Fourthly, the cures of homeopathy could all be explained by the natural healing powers of the body. It was admitted that no disease could be cured independently of Nature. Homeopathy's success, it was claimed, was due to the fact that homeopathic medicines acted in conformity with the recuperative and restorative powers of the body. If nature alone cured, it was argued, how could bleeding, blistering, purging and other debilitating therapies be justified by the regulars? Not at all, was the expected reply.(195)

Fifthly, homeopathy cures by faith and imagination. It was replied that if the faith of the patient was what homeopathy depended upon then there was little evidence of it in the populace at large. If it was imagination how could the cure of children and animals be explained, it was asked by the homeopaths. [It was then standard belief that children and animals had no imagination].(196)

Sixthly, it was claimed that homeopathic cures were actually due to severe regimen. It was accepted that regimen was important in the management of disease, but it was only accessory to its treatment. It was not a principal point in such treatment.(197) The rhetorical question was asked -

"if Homoeopathy is enabled to cure so many severe disorders by simple regimen alone, why does not Allopathy adopt the same gentle means, and how can all the violent and complicated measures, to which it resorts so unsparingly, be justified".(198)

Seventh, it was charged that homeopathy could not be depended upon in acute diseases. To which came the reply "An appeal to the main test of empirical medicine, experience, must decide the question".(199)

It was further pointed out that acute cases of all kinds occur in regular practice as well as homeopathic. Then it was claimed that less patients actually died of acute diseases under homeopathic care, and when they did it was latched on to with great eagerness by the regulars, as if they never had patients with acute diseases die in their care.(200) For example, the average rate of death in cholera cases under homeopathic treatment, it was claimed, was 8½-9%, whereas the regulars experienced 50% mortality.(201) Luther then provided reasons why homeopathy was so

successful and also why it sometimes failed.(202)

Eighth,that homeopathic cures only occurred after severe aggravation for the patient. This was either the fault of the practitioner sometimes continuing with a medicine, which was not working, for too long; or it was the sensitivity of the patients constitution. Often the aggravation was transient and harmless, and most cases improved.(203)

Ninth, it was asserted that it was 'quackery'. Such a judgement must be left to the reader to make, but as regular practice fell into the hands of quacks, so too did homeopathy, was the reply.

"But Homoeopathy can be no more responsible for their proceedings than Allopathy is for those of allopathic quacks".(204)

Tenth, many persons, it was objected, had been treated but not cured by homeopathy. The reply was that -

"It was clear that there never will, nor ever can be, a medical system which will cure all diseases without exception, and if one with such pretensions were ever brought forward, it would deserve to be stigmatized as quackery. Homoeopathy has no such pretensions, and all it claims is being a system of practical medicine, based upon a law of nature, insuring clearness and simplicity

in the treatment of diseases by means of fixed rules and principles.(205)

The sources of such failure were common to homeopathy and regular medicine, i.e. the nature of the disease, the severity of damage to the organism, the want of effective remedies, constitution of the patient, the interference of well meaning relatives and nurses, the patient not following the physician's advice, lack of patience by the sick person in the efficacy of a cure, the imperfections of homeopathic treatment and the homeopathic practitioner.(206)

Eleventh, medical men, it was claimed, had tried it and found it untrue. This, it was admitted, would be the source of the most damaging criticism if the claimed experiments by regular practitioners had actually been practiced according to proper homeopathic principles, methodology and correctly prepared medicines. In short, the failure to appreciate the subtleties and craft skills of proper homeopathic practice was at the root of their falsely claimed 'refutation' of homeopathy.(207)

Lastly, regulars claimed homeopathy was "going down everywhere".(208) This was easily refuted, according to Luther, by a simple enumeration of the numerical growth of homeopathic practitioners, societies, hospitals, journals and dispensaries in Great Britain, America and Europe.(209)

The professional homeopaths recommended Luther's concise summary of homeopathy, the standard objections brought against it and their refutation, as providing a general view of the subject. It also functioned as a handbook upon,

"what can be said in defence of much abused and little understood Homoeopathy".(210)

Such 'objections' from the regulars and their 'refutation' by the homeopaths is discernible in the evidence already presented on the ideological work of the Lancet, P.M.S.A./B.M.A., Forbes on 'Homeopathy, Allopathy and Young Physic', the works of Henderson and Simpson and so on. It persisted right to the end of the century with the resurfacing of a similar dialogic ritual in the 'Odium Medicum' conflict which occurred in the pages of 'The Times' during 1887.(211) This was over the issue of a regular surgeon, Mr. Kenneth Millican, being sacked from the Queens Jubilee Hospital by ten members of its management committee because it was discovered that he was also practising in the Margaret Street Infirmary. Not that that was anything abnormal; many practitioners worked for more than one hospital or dispensary. What was so unforgivable according to the management of the Queens Jubilee Hospital was that Mr. Millican was practising his profession knowing that some other practitioners there were treating patients homeopathically. Millican

brought an action against the ten managers who had sacked him. He won the case in the law court but lost the appeal. Between those legal proceedings the issues broke into 'The Times' letters column and the bar of public opinion had its say, with no exact conclusion either way.

In conclusion, the routinized aspects of ritual debates, between regular and homeopathic medical systems of thought and practice, enabled each to neutralize the criticisms of the other, thus reducing any psychic anxiety these cognitive conflicts may have generated. Answers to criticisms were standardized into basic forms, as were the criticisms themselves. An illusion of cognitive stability was created as was the further illusion that the theoretical combatants had criticisms and answers which were definitive, devastating and final in relation to the other side.

5.8 Conclusion

This chapter has described the basic institutional, legislative, political and ideological framework within which regular and homeopathic practice operated. Within the established asymmetries of power between them the homeopaths were able to locate an ideological and institutional niche through the resourceful support of their aristocratic patrons and other supporters, as well as their own market attributes of a distinctive set of goods and services.

Even though the anti-homeopathic campaign was intense

and long-term the professional homeopaths were able to so deploy their own authoritative resources of patrons and supporters, in strategic political positions, that the reciprocal nature of the asymmetries of power enabled them to resist the attempts to suppress and eliminate them in 1855 and 1858 respectively.

Finally, in certain ways the ideological interests involved in the conflicts of the regulars and homeopaths, ritualized large areas of the debate between them at the level of the theory and practice of their competing medical cosmologies. The result was the degeneration of debate to a level of theoretical stagnation, thus neutralizing the possibility of fruitful dialogue for the rest of the century.

From this point we can gather the historical materials together and begin to bring about a more adequate theory of the monopolisation thesis by developing an informal descriptive theory of marginalisation.

CHAPTER SIX

At the Margins of Medicine: Towards the Recovery of the History and Sociology of Medical 'Heresy'

6.1 Introduction

This penultimate chapter has two main aims which will draw together the previous materials and also go beyond them in a fruitful way. Firstly, to propose concepts of power, domination, control, deviance and stigma necessary to further historical and sociological consideration of medical monopoly and marginalization. These concepts will also function as orientation points in the attempt to construct something of a descriptive theory of marginality. Although drawing from quite specific historiographical and sociological materials, hopefully the attempt at a descriptive theory may be adapted to the consideration of the 'monopolization/marginalization' processes of other historical phenomena.(1)

Secondly, to describe certain aspects of the conversion of some regular practitioners to homeopathy and locate this within recent theoretical and empirical work on alternation (or identity transformation), the social psychology of conceptual shifts, commitment and its maintenance.

I will then use the insights of this research to mount a critique of the standard history and sociology of medicine

in order to contribute to the reconstruction of a historiography and sociology of medicine which is more ideologically self-critical,[2] in the final chapter.

I will now develop these aims in the order given above so that the asymmetries of power in the production and reproduction of marginality can be made clear.

6.2 Marginalization and the Asymmetries of Power

The sociological work on marginality has been sparse. Besides concentrating upon marginality as an end-state or condition of a social collectivity, rather than as produced and reproduced by contingent but determinate social processes, it has tended to be almost solely considered in terms of racial or ethnic minorities, often in conflict with a dominant culture.[3] A more fruitful approach can be gained by considering medical marginality, as the reciprocal consequence of processes and events which also bring about medical monopoly. The duality of these processes and structures of monopoly/marginality need integrating into recent substantial and systematic sociological work on concepts of power, structures of domination and subordination, reciprocity of control in social interaction systems, ideology and sectional interests, and deviance as a property of social and system integration. In this way the rather stagnant work on marginality can be considerably advanced.

6.2.1 Power

At its most general, power is the 'transformative capacity'[4] of social agents. This refers to -

"the capability of the actor to intervene in a series of events so as to alter their course".[5]

Being such a pervasive feature of all social life the foregoing chapters (4-5 inclusive) demonstrate this capacity of homeopaths and regulars to intervene at crucial points in the ongoing systems of interaction and assymetries of power their relationship had produced. For example, the long-term capability of the regular practitioners to prevent the homeopaths gaining the 'sacred' legitimacy of scientific status by a fairly continuous ideological conflict with them which engaged the standard policy of exclusion from regular medical societies, colleges and professional association. The intervention of Frederick T. Gates, in 1910, to prevent the homeopaths having the 'Law of Similars' experimentally tested by the Rockefeller Institute is a specific case in point of the monopolization of the rhetoric of science by the regular practitioners and their 'neutral' supporters, such as Gates.[6]

However, no power, even that based upon the various monopolization strategies, is ever total.[7] That is to say, no dominant group is ever totally dominant over, or auto-

nomous from, other groups. Hence, subordinate or dependent groups are able to resist the control of the strong by using what resources they do have in strategic ways. For example, the capability of the professional homeopaths in Britain to mobilise their patrons, inside and outside parliament, to rescue their cholera statistics from the oblivion the Treatment Committee of the General Board of Health had tried to consign them after the 1853-1854 cholera epidemic. Or, the successful averting of their possible extinction by the strategic use of their patrons to amend the 1858 Medical Bill at various points so that the practice of homeopathy was no bar to being included on the medical register as a legal practitioner.(8)

6.2.2 Autonomy and Dependence

Power, in its narrower more relational sense, refers to persistent relations of autonomy and dependence at institutional and face-to-face levels of interaction. In other words it describes relations of domination and subordination between individual or collective agents. Power, in this sense, refers to the capability of agents to gain outcomes whose realisation is relative to the action of others. In other words, the outcome of agent interaction is relative to the resources they can each apply to intervene in a series of events, or a course of interaction, such that they influence its course: as has

already been described in relation to the 1853-54 Cholera Epidemic, 1858 Medical Act and successful deligitimation of homeopathy by various ideological strategies of the regulars (to be described in more detail at 6.3).

At the face-to-face level of interaction power is exercised through the communication of meaning and normative sanctioning. For example, the vocabulary of insult and the tactics of intolerance employed by the regulars through the medical press was of sufficient intensity and regularity throughout the century that it effectively labelled the homeopaths as 'charlatans', 'quacks', 'irrational' and 'unscientific' well into the twentieth century. In fact, even today when the professional homeopaths apply for a research grant it is routinely refused on the basis that they are 'unscientific'. Such deviantization of the homeopaths, by means of a stigmatizing vocabulary of insult, communicates certain meanings to those who hear or read such terms in the context of talk or text, no matter how misinformed about the theory and practice of homeopathy it is. In this way misinformation and virtual ignorance is created about homeopathy. Its thought and practice is presented as a static set of dogmas accepted by faith. In fact it was a developing system of knowledge which was open to new knowledge from the basic medical sciences and practical innovations which would be useful tools in the practice of medicine. It is also the case that if homeo-

pathic practices regarding cholera treatment could have been used by regulars, even on an ad hoc empirical basis, many more lives could have been spared from the epidemics which swept Britain and Europe throughout the century.

Equally, the homeopaths developed their own vocabulary of insult in order to defend themselves and to undermine the plausibility of regular practice as a prelude to the reform of its therapeutics. However, the vocabulary of insult communicated through such terms as 'sectarian', 'bigots', 'old school of medicine' and 'unscientific' seems more concerned with the response of rejection from the regulars than from any intensive campaign by homeopaths to eliminate them as competitors.(9) After all, unless there were massive numbers of conversions to homeopathy it was unlikely that such a strategy could ever succeed. Thus they opted for a triple-pronged strategy of: progressive evangelization of the regulars as opportunities arose;(10) homeopathic schools of medicine to train those who were convinced of homeopathic claims;(11) and minimization of differences if at all possible,(12) whilst still continuing to defend themselves from the more overt attempts to eliminate or neutralize them by the regulars.

6.2.3 Structures of Domination and the Asymmetry of Resources

The rhetoric of conflict instantiates relations of autonomy/dependence in respect of the differentials of

power based upon the structures of domination/subordination. The latter is itself shaped by the structural asymmetry of the resources each group can draw upon in (a) maintaining or (b) altering those relations and structures of power. Even though those relations of autonomy/dependence are not totally in favour of the dominant group because -

"even the most autonomous agent is in some degree dependent, and the most dependent actor or party in a relationship retains some autonomy"[13].....

nonetheless such relations are organized in terms of "structures of domination" which "involve asymmetries of resources employed in the sustaining of power relations in and between systems of interaction".[14]

The resources employed by the medical profession, with its component estates and sectional interest groups, are largely those of the authoritative type which generate command over persons.[15] This command is itself based upon the value accorded to certain symbols of authority by people and to which they will respond in determinate ways. These are the socially valued resources of status, privilege, rank, honour, esteem, prestige, expertise, established tradition, reason, charisma and so on. These resources, then, are deployed in the mediation and reproduction of structures of domination outlined in chapter

one.

For example, the status hierarchy of the medical estates in nineteenth century Britain was the product of long-term institutional processes in which the physicians were able to gain certain social and legal advantages from their university education, political patronage networks and occupational service ideology. This enabled them to dominate the organised estates of surgeons and apothecaries and thereby control the definition of work-task boundaries. However, the effectiveness of this control changed as the estates sought to variously consolidate, extend or defend existing privileges, status and social honour. Indeed -

"The very existence of status groups is dependent upon the monopolization of attributes,.....which confer upon their members the exclusive right to social honour".(16)

Conflicts over work-task boundaries, privileges and status between the medical estates arose not just because power was exercised but because it was exercised in accordance with competing sectional interests.(17) Since monopolization involves the attempt by a group to control the outcome of competing interests in its own favour, a key factor in this is the deployment of a legitimating ideology which is largely accepted by the subordinate groups and provides normative sanctioning for the status quo, or its

minimal alteration. This is accomplished by the dominant group universalizing its sectional interests and thus setting the basic parameters for future discourse. However, the subordinate group may be able to maximize its interests in line with contingencies outside the direct control of the dominant group.(18) For example, the legislative and ideological dominance of the regular practitioners began to crumble somewhat in the United States during the 1820's and 1830's. This was because the anti-heroic medical reform movement was able to strategically use the political philosophy of Jacksonian, populist, democracy in a campaign against the monopolistic licensing advantages of the regulars. Yet this proved to be of limited success as it did not prevent the persistent and systematic exclusion of the homeopaths from gaining professional legitimacy in the eyes of practitioners of whom they were the intellectual, social and professional equals. It would seem they were also the therapeutic superiors of the regulars until the innovations of the bacteriological-laboratory research programme in the last quarter of the century.

It is important to note that power is not only exhibited when a dominant group effectively overcomes the resistance of others. Or, when a subordinate group resists the sectional interests of others. Or, when there is overt conflict as is highly likely in the previous two situations.

Power is also exercised when other groups are indifferent to, or supportive of, the sectional interests of a dominant group. It may be empirically related to conflict but there is no logically necessary connection to it.

What is apparent is that the exercise of power according to the sectional interests of groups not only generates conflict between them but also solidarity within them.(19) This we have seen is particularly so in the ideological conflict between the regular and homeopathic practitioners. Indeed the evidence regarding the shape of this ideological conflict shows that although the regulars may differ - sometimes violently - amongst themselves regarding proper medical practices, especially therapy, they were virtually unanimously united against the 'homeopathic heresy'. Conversely, although the homeopaths disagreed as to the relative importance of secondary theoretical issues of therapeutics - like dilutions - they were united over the 'similia' principle. For many of them this meant that it should gain its rightful place within 'orthodoxy' and that they should oppose the sectarian exclusivity of the regulars towards their principled practice of homeopathic therapy.

The exercise of power in these and other circumstances is not a certain kind of isolated act, although it is instantiated in action, but a regular, routine phenomenon of social interaction. Neither is it a resource like

status, prestige, social honour or property but it is mediated through such resources and thereby reproduces socio-historically specific structures of domination. These are evident in the programme of the regular medical profession to gain and maintain certain advantages from the polity in order to effect social closure against unlicenced and heterodox practitioners. In order to maintain their control over state hospitals in the United States regular practitioners actually withdrew their labour from them if homeopaths were, or tried to be, appointed to them. However, such a tactic did not always go in their favour because of the contingencies of local circumstances and differentials of power, resources and strategic intervention opportunities.(20) Such events further underline the fact that the marginalization of the homeopaths was not an ineluctable process which inexorably resulted in the total and inevitable powerlessness of them as a collectivity. Indeed, no group is totally powerless in the face of dominant established social systems which symbolise themselves as the repositories and guardians of 'orthodox' knowledge and practice.

The relationships of conflict, semi-co-operation, partial assimilation and ideological containment by the regulars towards the homeopaths is not just the product of the exercise of their monopolizing domination of the division of medical labour but also of the shape of homeopathic

resistance to and intervention in the exercise of power. This latter capability is premised upon the reciprocity of control within structures of domination/subordination.

6.2.4 Domination, Subordination and the Reciprocity of Control: the Context of the Marginalization of Homeopathy

The mobilisation of the ideology of the 'gentleman-physician' and 'professional service' legitimated the forms of domination constituted as a status hierarchy of the medical estates.(21) This class based, educationally organized and culturally legitimated stratification system was modified to meet the frontier conditions of post-colonial America. It may not have been as hierarchically elitist as the British estates but there was certainly a basic hierarchy organized according to education, expertise, income and whether one was urban or rural, East Coast or Western interior, metropolitan or small town.(22) The ethical codes of medical societies, estates and other associations functioned to sustain professional relationships within these structures in ways that reinforced differentials of social honour between practitioners. In short, ethical codes are forms of normative sanctioning and, like power, they are a pervasive feature of social interaction.

Each dominant group has an obvious interest in maintaining, even extending, its domination. This is particularly so with occupational status groups such as professions.

In order to defend its domination, extend its monopoly and hence control the economic uncertainties of a laissez-faire medical market place, it has excluded certain groups - if possible - from the benefits of that (relative) monopoly. On the other hand it is in the interests of subordinate or excluded groups to resist the control strategies of dominant ones. The deployment of the strategies and tactics of control by the monopolising dominant group(s) are largely responsible for the marginalization of the homeopaths. However, their own strategies and tactics of resistance may inhibit or even exacerbate the degree to which marginalization occurs.

The relationships of power, monopolization and marginalization are expressed "in the capabilities of actors to make certain 'accounts count' and to enact or resist sanctioning processes".(23) Those 'accounts' which count more than others, do so because of the differentials of power which are elaborated in terms of frames of meaning, social cosmologies, or legitimating ideological symbol systems. The asymmetries of power and the structures of domination/subordination operating as medical monopolization mean that what passes for the occupational and epistemic 'reality' of medicine is weighted in favour of the monopolizing group(s). For the regular medical profession this was due to its securing of legislative advantages from the polity, its patronage, service

ideology, mobilization of authoritative resources (like claims to expert knowledge), numerical strength and organizational capabilities .

The homeopaths were prevented from successfully challenging this domination due to lack of numbers, limited patronage, limited authoritative resources and limited organizational capability. Their own self-conception as a profession was also completely parasitical upon that of the regulars. Hence they held a socially ambiguous and anomolous place as far as the regulars were concerned. For although they may be their professional equals how could they be regarded as 'sane' if they believed in those dilutions. If they claimed to be 'rational' and 'scientific' as well, then 'orthodoxy' could charge them with not only being 'insane', 'irrational', and 'unscientific' but 'evil' too. This stigmatized version of homeopathic claims came to be counted as 'social reality' by the regular profession and it was produced and reproduced on the basis of specific strategies and tactics of control. This version of the 'reality' of homeopathy was firmly resisted but to little avail in the long run. The delineation of the strategies and tactics of control and their resistance is termed the reciprocity of control.(24) The capability to resist the control of a dominating group(s) is based upon the knowledgeability of those offering resistance, of the conditions of domination and the strategic use of their

own resources. By such means the homeopaths attempted to neutralize, modify or repudiate the systematic ignorance and misinformation about their beliefs and practices produced by the anti-homeopathic, armchair theoreticians of the regular profession.

The institutional analysis of the structures of domination reproduced by monopolization and its intrinsic forms of social control refers to -

"how resources are manipulated strategically by actors in order to sustain control over the activities of others. Forms of control here simply refer to the modes in which actors apply knowledge to maintain asymmetries of autonomy and dependence in the reproduced relations constituting social systems".(25)

Simply put, the homeopaths may have become agents in an occupational system which was organized in favour of established medical groups but at least it was a system with some rules, even if they tended - in the long run - to favour the established groups, particularly the regular physicians. However, if enough support could be generated from the public and important patrons could be gained, those rules might be modified enough to permit the reform of regular therapeutics along homeopathic lines. Or, at least the recognition of homeopathy as a legitimate form of therapy,and homeopaths as part of the established

profession of medicine.

Historically the American homeopaths, by the end of the nineteenth century, achieved none of these possibilities and consolidated what was left of their distinctiveness and their institutions by forming a socio-cognitive ghetto in which to repair and renew what was left after the impact of the reform of the A.M.A, and the reform of medical education in line with the laboratory and teaching reqirements of the basic bio-medical sciences constituting clinical and bacteriological medicine.

In Britain, the professional homeopaths achieved legal recognition in the 1858 Medical Act, but further acceptance or scientific legitimacy was not forthcoming from the regulars. The issue to be considered now is, 'What modes of control were exercised by the regulars which produced the marginalization of homeopathy in general but professional homeopaths in particular?'. To this we will now turn.

6.3 The Strategies of Marginalization: Preliminary Remarks

The notion of strategies is used here to refer to the asymmetries of transformative capacities which organize significant patterns of regularised practices. These then shape the posture of relevant institutions and the basic relationship of their members with the homeopaths within the more circumscribed face-to-face contexts of

interaction. Hindsight permits the theoretical co-ordination of these strategies in terms of longer term 'programmes', or their tactical deployment in specific contexts. For example, the movement for the reform of the medical profession and medical education can be understood as a professional programme largely generated by upwardly mobile general practitioners. This included non-elite physicians, surgeons and apothecaries who struggled for their own status improvement and the occupational closure of the profession from unlicensed and heterodox practitioners.(26) In Britain they managed to achieve the exclusion of the former but not that of the latter, in the case of certificated, licensed and then registered homeopaths. In the United States of America, they eventually managed the exclusion of both from professional legitimacy in terms of legal acknowledgements. The deployment of strategies of manipulative coercion, symbolic legitimation of sanctions such as group inclusion-exclusion criteria, mobilization of bias and deviantizing stigma-contests,involved the tactical use of these mechanisms of control in the contingencies of social and system interaction.

However, the concepts of 'professional programme', 'strategy' and 'tactics' do not assume the logical, psychological, or sociological necessity of participants deliberately and consciously planning 'programmes',

'strategies' or 'tactics'. These terms are primarily post-hoc descriptions of the continuous flows of regularised practices in the contingencies of interaction over time and space. Yet, neither does it exclude the fact that something like deliberate, conscious planning could occur. For example, the writing of pamphlets, books or other articles, for internal and external consumption, on the weaknesses, strengths and necessary reforms of the profession could certainly be regarded as the attempt by some to map out a programme of reform and the means to acieve it.(27)

To repeat: there is no necessary discursive planning component to the notions indicated above since much of the social action constituting these post-hoc reconstructions "operates in conjunction with unacknowledged conditions and outcomes of action".(28)

Broadly speaking, 'professional programmes' are analagous to social movements which are (a) well organized, have (b) competent leadership, (c) member commitment, (d) capacity to mobilize their power resources and (e) pursue a definite objective.(29) 'Strategies of marginalization' - the reciprocal concommitant to the 'strategies of monopolization' - are the necessary control mechanisms generated by differentials of power, resource mobilization, legitimating ideology and interests of dominant groups. For example, the stereotyping and

deviantization of the homeopaths in order to secure their delegitimation. Such deligitimation occurs in relation to various master symbolic significations within professional culture, like the claims to be 'professional' or 'scientific'. 'Tactics' may be understood as analagous to the interpretive enactments of organizational 'policies' in specific interaction settings. They employ resources, power relations, sanctions, ideology, structures of domination and control strategies in specific contexts, over specific issues, against competing/threatening groups. Throughout these different but connected arenas of interaction the contingencies of social agency are ever present: as when the unanimous proposal of the Treatment Committee to exclude the homeopathic cholera treatment statistics from the government report of 1855 failed to achieve that end, not because it was strategically unsound, but because it was tactically inept. It was inept because the proposal ignored the high-profile, public character of the production of the report and underestimated the response of the homeopaths, through their parliamentary patrons, to be able to capitalise upon the moral and professional injustice of the whole affair to their virtual complete advantage.

Considering the groundwork established in the opening chapter on monopolization it hardly seems appropriate to re-examine those factors which operated in the dual

direction of monopolization and marginalization. For instance, there was the restriction of professional membership by group entry criteria, especially of the credentialist kind. The suppliers of regular medicine were united through the normative sanctions of professional ethics and etiquette, not only in relation to each other and the lay public but over their collective economic behaviour. Group solidarity was strengthened through occupational associations, the medical press and consultation codes. Lastly, attempts were made to persecute, prosecute, eliminate or neutralise non-regular competitors.

What does seem appropriate is the further explication of processes which seem to have had the most politically and publicly significant effects upon the continuing relations of regulars and homeopaths. These are the processes of deviantization, stigmatization and purification. Although these marginalising processes are not empirically separable they are dealt with separately, below, for theoretical purposes. This will enable some connections to be made with the previous concepts of power, domination and control.

The processes of deviantization, stigmatization and purification will be dealt with in more theoretical terms in order to achieve two objectives. First, to underline - but not to re-state - the thesis already made that due to

the immature and ineffective evaluative criteria regarding therapeutic efficacy and action, within heroic and clinical medicine, homeopathy was rejected by the regular medical profession for other than the claimed scientific reasons.(30) Second, to describe the main socio-political mechanisms and interests which constituted the primary dynamic of such rejection.

6.3.1 Deviantization: the Production and Reproduction of Medical Deviance

This process empirically includes those of stigmatization and purification. Theoretically and analytically it refers to the capability of a dominant and - in this instance - a monopolizing configuration of regular practitioners to collectively make their account of the 'social reality' of homeopathy come to rule as the definitive account: minimally within the occupation of professional medicine, maximally within the wider political and cultural spheres.

Such an outcome was the result of the ideological conflicts generated by the mobilization of antagonistic sectional interest, within the asymmetries of power, between the competing medical systems.(31) This conflict necessitated the deployment of 'vocabularies of insult and stigma' by a dominant group and the power to make such terms count as the 'true' social definition of homeopathy. In professional medicine this task was achieved

by the mobilizing of the structures of domination, sectional interests and a delegitimating ideology (usually a stigmatizing one). The stigmatizing ideology was derived initially from stocks of routine knowledge. These were 'stored' as an anti-quack rhetoric within the historical traditions and stories of the profession.(32) However, in order for such a general tradition to be extended to the homeopaths it needed specification work to be carried out. This was accomplished by some regular practitioners selecting themselves for the task of reading some of the homeopathic literature - with minds already made up regarding its heretical status - and producing a polemical debunking of the offending group's beliefs and practices. Polemical works against homeopathy could be written by either high-status practitioners, or those not long in the profession who were out to make a name for themselves by some deft 'quack-bashing', to earn the ego-affirming applause of their peers.

Oliver Wendell Holmes' polemic of 1842, "Homoeopathy and its kindred delusions" was produced between his being appointed Professor of Medicine at Dartmouth College in 1838 and Dean of Harvard Medical School in 1847. James Young Simpson produced his main polemic in 1853, entitled rather grandiosely, "Homoeopathy: its tenets and tendencies, theoretical, theological, and therapeutical". Simpson's successful application of chloroform anaesthesia in 1847 made him one of the youngest stars in the

firmament of the regular medical profession by the middle of the century. Holmes and Simpson both produced their anti-homeopathic work at the height of their medical careers. Alexander Wood was a young practitioner out to make an impression upon his peers by producing two quasi-academic polemics in 1844, entitled "Homoeopathy Unmasked; being an exposure of its principal absurdities and contradictions: with an estimate of its recorded cures" and "Sequel to Homoeopathy Unmasked; being a further exposure of Hahnemann, and his doctrines, in a reply to recent anonymous pamphleteers". (At least it can be interpreted that way).

Even with such a volume of anti-homeopathic polemic being circulated by publishers and the journals of the medical press, the nineteenth century professional homeopaths survived. In Britain they survived by exercising their own authoritative resources to bring themselves within the medical profession by legal definition in 1858. In the States they survived by various attempts at rapprochement, especially after the impact of the bacteriological revolution and 'Flexnerization' upon medical education. These different outcomes remind us that the processes of monopolization-marginalization do not always end in favour of the dominant regulars. They are relative to the mutual nature of autonomy/dependency and the reciprocity of control measures.(33) Even so, in the long term the conflict with the homeopaths took place within the

parameters of discourse, meanings, rules, symbols and power differentials created and maintained by the regular profession. Historically, the homeopaths may have won a few 'battles' but the regulars won the 'war'. Sociologically, though, such a situation is precarious because various economic, political, ideological and social configurations may change the balance of power. Thus, the regulars may find themselves declining in various ways and the homeopaths experiencing a renaissance, at a later date.

The above only partly explains why homeopathy was deviantized in the first place and how this 'reality' was sustained. The more detailed sociological explanation of these questions is to be sought by considering the function of the 'natural attitude' in identifying and maintaining 'deviancy'. Also how 'deviancy' disrupts routine practices and prompts the generation of the anxiety defences of orthodox practitioners.

(i) Deviancy and the 'Natural Attitude'

The "natural attitude" is that set of cognitions, models, learned responses and interpretive resources of consciousness which we employ in ordinary everyday life to make sense of routine and non-routine aspects of it. (So much of what is used to describe the regulars here, equally describes the homeopaths). So it is that:

"Everyday life as we experience it is possible because

the natural attitude makes it a taken-for-granted reality within which we go about our practical tasks with a firm sense of ourselves as real. We bracket, or put aside, any doubt or disbelief in the firmness of our conviction that life as we know it is indeed real, and we are indeed normal living persons".(34)

This "natural attitude" is the basis for the specialised cognitions of the medical profession. However, that expertise does not make their attitudes towards others, proposing and practising a different system of medicine, any more self-reflective or self-aware than 'lay' knowledge about the same 'odd' group. On the basis of their 'natural attitude' towards the homeopaths as 'heretics' the regulars were able to typify homeopathic knowledge, behaviour and motivation in a way which did not correlate at all with the homeopaths' own subjectivity about themselves. This is why they were so outraged and affronted at the prejudices apparent in the talk and texts produced by the regulars about them.

From the perspective of the 'natural attitudes' of the regular profession the homeopathic cosmology was perceived as 'deviant' and hence as a threat. It was perceived in this way because it did not accord with the 'normal' expectations and causal paradigms of the regulars. The beliefs of the homeopaths were considered not just a deviation from the plumb-line of 'orthodoxy', but a

contradiction of reason, experience, tradition, science and sanity. In this sense it was a 'heresy'. A set of beliefs and practices which fundamentally ran counter to 'orthodoxy'. While it continued in its 'deviant' beliefs and practices homeopathy could be treated and labelled as such. Sociologically such terms as 'orthodoxy' and 'heresy' are relative to differentials of power, domination and mechanisms of social and ideological control.(35) In the framework of the 'natural attitude' medical heresy is extremely threatening because it brings into question all the taken-for-granted beliefs and routines of everyday, regular medical life. It was doubly threatening when those who were the heretics were formerly one's medical brethren.

(ii) Routines, Deviancy and Ontological Security

It has been established that the routines of daily medical life ground the thought and practice of a medical system in the 'natural attitudes' of the taken-for-granted nature of everyday experience. The routines of belief and practice provide the continuity of the structured order of the professional life of the regular practitioner (or any medical practitioner for that matter). As routines they take on the appearance of 'objective' features of medical life but are themselves the product of previous historically transformed practices. These constitute habits of thought and practice shared by an

integrated system of practitioners. As habits, or conventional beliefs and practices, these discursive aspects are taught and learned by normal educational means. Their tacit craft components are learned by active practical experience in a master-pupil, or guru-disciple relationship.(36) As such, habits of thought and practice are relatively unmotivated:

"That is to say, many of the most deeply sedimented elements of social conduct are cognitively (not necessarily consciously in the sense of 'discursive availability') established, rather than founded on definite 'motives' prompting action: their continuity is assured through social reproduction itself".(37)

It follows from this that routine practices and the 'natural attitude' are mutually reinforcing because both are saturated by the 'taken-for-granted facticity' of everyday medical life. It also follows that de-routinisation generates critical situations associated with the impact of fear or anxiety. (De-routinisation refers to any influence which erodes the taken-for-granted quality of everyday cognitions, attitudes and practices). The perceived threat of disruption, particularly if originating from within the medical social system, can produce a similar anxiety-reaction whether the de-routinisation is actual or anticipated.

If the medical system of the regulars was to survive the cognitive, social and affective threat the homeopaths posed, then the established beliefs, attitudes, cognitive outlooks and conventions had to be re-asserted and 're-grooved' as everyday routines. The source of the threat must be eliminated if possible. However, the reciprocal nature of power and control almost invariably meant that the homeopathic threat could at most only be ideologically contained or neutralized.

The psychological development of human beings seems to bear upon the implied relationship between routine, its disruption and the response of anxiety defence mechanisms organized by:

"a basic security system: capacities of tension - management in relation to organic wants".(38)

This system is extended, during the development of the person, to include emotional and cognitive security. The 'tying' together of these physical, psychic, cognitive and social security needs is accomplished by the hierarchization of those needs in relation to the deep lying tension management system which attempts to preserve a sense of 'well-being-in-the-world'. In short, the maintenance of ontological security. As has been said before, and it bears repeating at this point in the argument, sociologically speaking:

"Ontological security can be taken to depend upon the implicit faith actors have in the conventions (codes of signification and forms of normative regulation) via which, ... the reproduction of social life is effected. In most circumstances of social life, the sense of ontological security is routinely grounded in mutual knowledge employed such that interaction is 'unproblematic', or can be largely 'taken for granted' ".(39)

It is not difficult to conclude from the foregoing that the continuity of routine beliefs and practices in the regular medical profession is closely related to the maintenance of the ontological sense of security. This is afforded by the relatively harmonious meshing of affective, social and cognitive commitments within the regular medical cosmology.

Where routine prevails, often in the form of received tradition, it usually does so because the evaluative criteria of medicine are immature and ineffective in assessing alternative competing systems like homeopathy. Since "routine is strongest when it is sanctified, or sanctioned, by tradition"(40) the strongest reaction of the ontological security system - or anxiety defence mechanism - can be expected when those fundamental routines, expectations, beliefs and practices are challenged. This was precisely the reaction of practitioners working within the heroic and clinical

cosmologies.(41)

(iii) Anxiety Defences and Deviancy

It is clear that the homeopaths posed a particularly deep threat to the social, cognitive and affective security of the regular profession. The depth and intensity of this perceived threat is indicated by the moral intensity of the stigmatizing vocabulary which was used to deviantize and denounce the homeopaths, (see section 6.3.2 below regarding this vocabulary).

However, some like Worthington Hooker conceived of homeopathy as not only a threat to regular medicine as an ethical and scientific occupation, but also as a threat to the very fabric of the social order (see section 4.3 p.250). This seems to support the idea that systems of social control can be interpreted as functional defences against psychic anxiety. Or to put it another way, the symbolic legitimations and normative sanctions of social systems, function as social defence mechanisms.(42)

Medical cosmologies are fairly comprehensive frames of reference, for particular groups of practitioners, over a specialized sector of institutional life - mainstream or marginal. They have their 'officially' recognized definers of medical reality: the institutional and intellectual leaders of specific medical organizations. As has been argued above, deviancy from 'orthodox' medical

reality becomes a threat if:

"the deviant version congeals into a reality in its own right, which, by its existence within the society [sic: regular medical profession], challenges the reality status of the symbolic universe [sic: regular medical cosmology] as originally constituted. The group that has objectivated this deviant reality becomes the carrier of an alternative definition of reality [sic: medical reality] .....such heretical groups posit not only a theoretical threat to the symbolic universe [sic: regular medical cosmology], but a practical one to the institutional order legitimated by the symbolic universe [sic: regular medical cosmology] in question".(43)

The nature and depth of the threat, the relations of autonomy/dependency, structures of domination, reciprocity of control and legitimating ideology all conditioned the kinds of measures taken against the deviant homeopaths. On the whole they were repressive measures designed to exclude known homeopaths, or to make the costs of conversion to homeopathy high. The success or failure of these measures was related more to the differentials of power between the regulars and homeopaths than to the ontological status of the competing concepts and practices, or the theoretical ingenuity of competing sets of practitioners.(44)

The kinds of control systems used have been mainly described in the theoretical typification of monopolisation (see chapter 1). Yet despite their variety two main applications of anxiety defence/ontological security systems are discernible - therapy and de-legitimation,[45] (or elimination).

(a) Therapy

This refers to the application of social and conceptual machinery to prevent the contingencies, paradoxes and anomalies of regular practice, as well as the doubts and uncertainties of regular practitioners, from (a) eroding their basic faith in the regular medical cosmology, (b) loosening their commitment to its theory, practice and social organization, and (c) preventing regular practitioners from 'emigrating' out of practice altogether, or converting to homeopathy (or any other marginalised medical cosmology).

The specific machinery created for this boundary maintenance and reinforcement function included licensing and other legal privileges gained from the polity, the rewards of career and recognition within the profession, membership rules of voluntary medical and medico-political associations to prevent deviants from joining and expelling them if found to be members. There were also all the forms of normative sanction respecting professional ethics,

etiquette and rules of consultation. Lastly, all the medical text books conceptually reproduced and re-affirmed the reigning orthodoxy, whilst the polemical literature debunked and stigmatized homeopathy as a 'heresy'. In short, the costs of contact with,or conversion to the offending heresy,were high.

"Since therapy must concern itself with deviations from the 'official' definitions of reality, it must develop conceptual machinery to account for such deviations and to maintain the realities thus challenged. This requires a body of knowledge that includes a theory of deviance, a diagnostic apparatus, and a conceptual system for the 'cure of souls' ".(46)

The substantive contents of these requirements in relation to homeopathy are quite straightforward. The body of knowledge that included a pathology of deviance - although the latter is implicit and not normally discursively accessible, except in anxiety or threat situations - was whatever was taken to be the regular 'orthodox' medical cosmology at any particular period in the development of mainstream medicine. 'Deviancy', given the 'natural attitude' by which theory and practice were rendered routine and taken-for-granted, was a divergence - large or small - from 'normal' cognitive, or behavioural expectations. If the divergence was such that it actually began to undermine the foundations of orthodoxy it could

be considered a 'heresy'.[47] The regulars explained the practitioners (and supporters) of homeopathy by stigmatizing them in five basic areas, thereby defining their deviancy as caused by any one or combination of these factors. Namely, they questioned their rationality (homeopathy was irrational and unscientific), their sanity (it was insane and incredulous), their professional ability (it was practised by those who couldn't succeed in regular medicine), their integrity (it was an utter tissue of lies), and their morality (it was a trick, deceit and a demonic delusion).

The 'diagnostic apparatus' functioned to provide an answer to the question, 'How can homeopathy be identified?'. Very simply, this was done by noticing who talked or wrote affirmingly of homeopathy, or at least did not offer convincing, or standard, or any criticism of it whatsoever. Obviously those who admitted they were using homeopathic remedies, amongst others, were suspect. Those who confessed to outright commitment to homeopathic theory and practice were clearly identifiable. However, those who were homeopaths but kept it a secret were harder to identify. Circumstantial evidence gleaned from other practitioners, ex-patients of homeopathic practitioners, as well as rumour and gossip, could be used as provisional indicators of possible 'heretics'. In addition, those known to break the 'consultation clause' were suspect

until culpability or ignorance could be proven. Finally, those who were not averse to working alongside homeopaths in dispensaries, hospitals or other medical institutions were also brought under suspicion since it was a moral rather than a literal infringement of the consultation clause.

As for the 'curative apparatus' it was very simple. It was based upon the operation of the stereotyped pathology of deviance within the ideological interests of the regular profession. Even though a distinction could be made between closet, incipient and full-blown homeopaths the 'cure' for their condition was identical: public confession and repentance of all past homeopathic 'sins' in word, deed and thought. There was something very ecclesiastical about this aspect of the therapy developed by the regulars. It shows quite clearly that terms such as 'faith', 'evil', 'heresy', 'truth', 'trust' and 'dogma' were not incidental to the structure of the discourse established between the regulars and homeopaths in their ideological conflict.(48)

For those who submitted to 'therapy' but continued in heresy, as well as those who refused to submit, the final mechanism for culpable heresy was that of expulsion from the regular profession as a whole and exclusion from social intercourse on subsequent occasions. Thus the 'alien heresy' of homeopathy was cast out and the profession further purified from its 'contamination'.

(b) Elimination

Much of the substantive and specific contents of this process are dealt with under stigmatization (see section 6.3.2 below) so the discussion here will be limited to some general points about elimination.

It uses similar social machinery to therapy but their functions are tied to particular outcomes. Namely, the liquidation, neutralization or conceptual re-appropriation of that which is considered in opposition to orthodoxy. Just as legitimation processes maintain orthodoxy (and homeopathy) as a medical reality, so de-legitimation processes attempt to deny that reality in various ways. Two basic ways of doing this are involved:

"First, deviant phenomena may be given a negative ontological status, with or without a therapeutic intent.... The conceptual operation here is rather simple. The threat to the social definitions of reality is neutralized by assigning an inferior ontological status, and thereby a not-to-be-taken-seriously cognitive status, to all definitions existing outside the symbolic universe (sic: regular medical cosmology)".(49)

The stereotyping of homeopaths as 'insane', 'immoral', or 'evil' enabled them to be reduced to less-than-human status and so legitimate their subsequent (mis)treatment. Second, there may be attempts to account for all deviant

definitions of reality in suitable terms (often modified), from the conceptual resources of orthodoxy. This shifts the relationship from heresy identification, treatment and exorcism to one of apologetics. The apologetic side of elimination mechanisms were an attempt to neutralize the heresy's conceptually antagonistic components. If successful, attempts may be made to reclaim and re-integrate the 'heretics' in a gesture of professional catholicity, (i.e. 'Catholicity' in the sense of a recognition of some basic doctrinal unity of the regulars and homeopaths and from that to proceed to organizational unity). Such a gesture was only possible theoretically. What was empirically available was the possibility of professional ecumenicity, (i.e. 'Ecumenicity' in the sense of working together were doctrinally and organizationally possible but recognizing that there were fundamental beliefs which made them doctrinally distinct. Such differences were to be recognized and mutually respected as each other's distinctive contribution to the total profession). This desire for a mutually respectful doctrinal dialogue was clearly present in some papers of the professional homeopaths writing in the British Journal of Homoeopathy.

In fact the imprimatur of the journal was 'In certis unitas, in dubiis libertas, in omnibus charitas' (i.e. In things certain unity, in things doubtful liberty, in

all things charity), which was the watchword of the Evangelical Awakening of the late eighteenth and early nineteenth centuries. The members of the British Homoeopathic Society were certainly in sympathy with such an aim since three of their members were also the editors of the journal (e.g. J.J.Drysdale, J.R.Russell and F.Black). The Society was also careful to keep a low political profile and not to give the regulars grounds for charges of unethical conduct.

During the 1870's in the United States of America the co-operation of the homeopaths had been sought and gained to set up state examination boards in a move to counter the rise of further irregular practitioners such as osteopaths, chiropractors and Christian Science healers. It worked well enough to push the new irregulars further West. It also demonstrated the principle of professional ecumenicity through the examination boards. Whether operated separately, or together, by the regulars, homeopaths and eclectics, there were common examinations in the basic sciences of anatomy, pathology, surgery and clinical medicine. The cost of this co-operation, to the regulars, was the toning down of state medical licensure laws so that the homeopaths and eclectics also benefited. For the homeopaths it also brought about access to institutions such as the municipal hospitals, Army, and Navy Medical Corps'. The cost to the homeopaths, in some

states, was the public confession of their therapeutic sins in order to gain admission to the professional fellowship of the regulars. For some the cost was too high and in their emphasis on keeping homeopathy pure from contamination, they split off to form the 'purist' International Hahnemannian Association.(50)

In Britain, the homeopaths regularly wrote about their desire to establish common ground for professional working relationships between themselves and the regular profession. It had been something developing amongst professional homeopaths since at least the 1860's, if not before.(51) A few important regular practitioners, like Sir John Forbes, attempted some kind of rapprochement towards homeopathy. In Forbes' case he did so by trying to establish the principle that homeopathy worked because it was a variety of expectant therapeutics whose efficacy could be explained by recourse to the ontology and principle of the 'vis medicatrix naturae'. Even though the homeopaths rejected his explanation(52) many regulars thought he had conceded far too much to them in his case. Forbes' position aroused enough opposition to probably provoke his resignation as editor of the 'British Foreign and Medical Review' in 1847.

Thus although gestures of co-operation and respectful dialogue emerged from both sides, within the regulars such practitioners seem to have been a minority and

usually not a significant enough minority. In other words, most regulars sought to at least contain and minimise the homeopathic heresy, at most to neutralize and eliminate it. The situation seems to have been quite the opposite amongst the professional homeopaths. Most wanted at least a professional working relationship which recognized their therapeutic distinctiveness:

"It is becoming evident to cultivated minds that medical practice is far from being in a satisfactory state, and that differences in the details of practice ought not to form a ground for professional estrangement.

These feelings should be met, it appears to me, in a spirit of conciliation and forbearance".(53)

Some homeopaths sought complete re-integration with mainstream medicine through the steady spread and acceptance of each other's therapeutics into each other's practices.

"We must not endeavour to establish separate chairs in existing colleges or universities, still less homoeopathic universities. But we must hope that the time is not far distant when by the leavening influence of homoeopathy among the body of medical practitioners the distinctive epithets of homoeopathy and allopathy, which are sectarian appellations, shall be merged in the one general name of the art of medicine, and professors of medicine or therapeutics in our schools will no more think of ignoring the

method of treating disease by specific remedies than they now do of the treatment by purgatives, counter-irritants, and other traditional methods".(54)

In conclusion: there were some exceptions to the general antagonism and anxiety demonstrated towards the homeopaths. However, these were not sufficient to prevent the systematic stigmatization and intended elimination of the homeopathic 'heresy'.

6.3.2 Stigmatization

Judged by the materialist causal paradigms of nineteenth century regular medicine, Hahnemann's theory of dilutions seemed a 'conceptual monster'. Thus, the ridicule it received was more intense than that directed at such features of homeopathy as the principle of similars. Such a response does not prove the claimed irrationality of the dilution theory but it does show the limitations of the established framework. Such a 'monster-barring' strategy not only operated at this cognitive level but also at the socio-political level mediated by the exclusion and elimination machinery.(55) These were introduced into the monopolisation-marginalisation 'programme' as it was developed by the transformative existentialities and contingencies of formative historical power exercised by the configuration of collectivities constituting the regular medical profession.

The socio-cognitive source of 'monster-barring' was located in the function of the regular medical cosmology as an interpretive resource and set of normative expectations regarding acceptable beliefs, behaviour and practices of 'orthodoxy'. Those beliefs, behaviours and practices which did not fit 'normal' cognitive and social expectations were labelled as 'deviant'. An important process in that was the stereotyped, negative labelling termed stigmatization.(56)

Stigmatization of the homeopaths directed the moral and emotional outrage of the regulars in a strategy to de-legitimate the former's beliefs. The intensity of the response helped cloud deeper issues regarding the actual ontological, epistemological, methodological and socio-political basis for the plausibility of regular medicine. This does not exclude sources of threat from other non-orthodox medical practices (e.g. hydropathy, or botanic medicine) but it does recognize that homeopathy constituted the most important threat to professional, regular medicine. Given the professional homeopath's basic socio-economic and educational equivalence and sources of income, the regulars had only two options before them. Either, to find common ground and minimize differences in order to eventually conceptually neutralize and engulf them; or to utterly denounce and exclude them from professional association. The latter was an attempt to conceptually

nihilate them and maintain their own supposed doctrinal purity. They chose the second course because they perceived the homeopaths as a moral and conceptual 'monstrosity' which ran counter to their expectations about 'proper' medicine.

As a social process, stigmatization tends to focus upon the spoiling of social identities (individual and collective) mediated by stigma-contests. These contests are the arenas for the reciprocal exercise of power, interests and ideologies.(57) Common to such contests is the process of negative typification, or stereotyping, by means of which those who perceive a threat seek to eliminate the source of that threat by negating the humanness of its practitioners or the conditions they find objectionable. To the extent that the regulars succeeded the heretical homeopaths were de-personalized:

"thus imposing personal stigma and providing a basis for collective discrimination against them".(58)

Like deviance, stigma is not an external, objective, immutable characteristic of a person's character or social being but rather the creative product of the socially conditioned biases tied to specific sectional interests and mobilized by and through differentials of power between dominant and subordinate social systems.

Stigmatized identities tend to carry a master (or monster?)

status (e.g. 'quack', 'heretic', 'deviant', 'charlatan' and so on) which over-rides all other considerations. Hence, the quality and equivalence of the homeopaths' educational credentials were ignored in the attempt to maintain their deviant master status. Thus, homeopaths were often spoken of in the same way as was used for 'empirics' and other 'unlicensed practitioners'.

Successful stigmatization entailed retrospective interpretation of present deviant status to be read back into past 'odd' activities, in order to bring it into line with contemporary discrediting (mis)information. This discrediting stigma can only be removed by reconversion back to regular medicine demonstrated by confession and repentance of past homeopathic sinfulness, or the re-integration and absorption of homeopathy back into a modified regular cosmology.

Unwillingness to accept deviantizing strategies brings into action various control tactics which aim to bring about a successful 'status degradation ceremony'. This refers to:

"Any communicative work between persons, whereby the public identity of an actor is transformed into something looked on as lower in the local scheme of social types...".(59)

The exemplar of this kind of moral indignation is that of public denunciation. This was certainly what the regulars

did and it is actually certainly what the homeopaths experienced in the stigmatizing rhetoric circulated by rumour, gossip, lies, horror stories, as well as all manner of pamphlets, books, journal articles, letters to the press and in the medical societies, of which many were members. Stigmatizing labels, such as the following, were frequently used against the homeopaths, their beliefs and practices: 'a moral pestilence', 'an abomination', 'an unclean thing', 'foul, wicked and treacherous', 'a deadly miasm', 'flimsy tissue of ignorance and deception', 'perverse', 'lifeless delusion', 'knavery', 'foolish', 'charlatan', 'pretended science', 'insane', 'incredulous', 'against all reason' and so on. Such collectively expressed indignation tends to reinforce group solidarity on both sides of the boundary defence/maintenance divide. The purpose of such rhetoric was the public, ritual, normative destruction of the designated homeopathic 'heresy' and the denial of any legitimacy it may have gained through the status symbols of medical credentials and high-status patronage from various social or political elites. The effect of this morally intense negative labelling was not only to de-legitimate the homeopaths but to underline the personal costs of defection. It also reinforced internal control mechanisms (e.g. consultation rules) which maintained relative compliance - calculative or otherwise - in public beliefs and practices of the regular profession.

The outcome of such stigma-contests (since both used stigma vocabulary), reflected the cognitive and moral evaluations dominant within the regular profession. That outcome, as has been said before, was not necessarily and straightforwardly in favour of the dominant regulars. Thus part of the struggle between them was the attempt to convince the polity and various publics to share and apply their value judgements, to make and impose their favoured moral assessments. Strategically, it was more cost effective in terms of time, effort and resources for the British regulars to concentrate their propaganda and political pressure upon a small number of M.P's and other influentials in higher circles. The homeopaths did the same but with a smaller set of resources. In addition, they attempted to appeal to a wider lay public for financial and authoritative resources. They were hampered by demanding medical practices and limited resources spread too widely. Their occasional successful resistances to the various control strategies of the regulars was not sufficient to gain for them the two things they most required. First, professional recognition and acceptance by the regular profession and second, scientific legitimacy.

In conclusion, once a monopolising medical group has collectively chosen the path of conflict with and elimination of heterodox competitors the stigmatizing of

the threatening group is important for the effectiveness of internal and external control mechanisms. The putting down of those who offend the cognitive, affective and social expectations of a dominant orthodoxy is important in the maintenance of relations of autonomy/dependence, structures of domination and containment of the perceived threat. In establishing a social stratification system the regulars also established a moral stratification system based upon the authoritative resources of social honour and political privilege. Labelled as 'deviant' the homeopaths were placed cognitively and institutionally outside this socio-moral hierarchy as far as was possible.

6.3.3 Purification

This refers to those socio-cognitive and institutionalised processes whereby power is exercised from within a social system and directed at identifiable, or potentially identifiable, actors who are 'carriers' (or even practitioners) of a cognitive heresy. The purpose of the exercise of this power is the expulsion of that which is perceived to pollute, defile or threaten the knowledge, beliefs, practices, social relations and continuity of the social system in question.

The pursuit of internal purity by the regular practitioners was mediated by the marginalisation process already described. The distinctive characteristic of the

purification process is that:

"The quest for purity is pursued by rejection".(60)

It could have been pursued by acts of forgiveness towards the 'heretics' but since individual anxieties and collective social honour was involved the probability of a charitable response was low. This meant that some of the authoritative resources of the regulars were divided between the identification and persecution of homeopaths within professional orthodoxy and defence against those external to their social system. Between the two sources of threat, the internal one was of greater potential for de-routinisation and the generation of anxiety. The collective response was to increase the social and personal costs to homeopaths of remaining as members of regular institutions. It also raised the costs of converting to homeopathy and made demarcation between the different medical cosmologies subjectively clearer to any convert to homeopathy.

The rejection of homeopathy was rationalised from the homeopath's side by the creation of separate institutions. It was legitimated by their theoretical and therapeutical antipathy to a theory and practice of medicine (particularly its heroic form) they considered as therapeutically irrational. In short:

"When the community (sic. medical orthodoxy) is attacked

from outside at least the external danger fosters solidarity within. When it is attacked from within by wanton individuals (sic. heretics), they can be punished and the structure publicly affirmed'.(61)

The operation of the 'consultation clause' was the main formal means of purifying the profession from the homeopathic 'heresy'. Informally, it could be made uncomfortable enough to make known homeopaths want to leave the medical societies and other medical organizations. The objectification of rules of avoidance within the regular profession's ethical code also functioned to make the boundaries of the profession visible to its members. The boundary-creating and maintaining functions of the 1847 and 1851 consultation clauses of the A.M.A and P.M.S.A respectively,is clear. They were reasserted by both organizations during the 1880's.(62)

However, although many means of exclusion were available to be used against homeopaths, public expulsion was rarely used lest it provide the person expelled, notoriety, or even a kind of martyrdom, if they resisted enough and it became public enough.(63)

Purity rules can be thought of in terms of normative sanctions which produce and are produced by pollution-avoiding activity. Unlike general ethical codes, pollution-avoiding rules are unequivocal. They only deal

with whether a forbidden contact has occurred or not. The intentions of the one contravening such rules are not a necessary factor in deciding what happened. However, a person's status, if high enough within the moral hierarchy of social honour, may mitigate the response somewhat. Although this does not invariably happen. For example, the concessions which John Forbes made to the homeopaths in his article of 1846 "Homoeopathy Allopathy and 'Young Physic'" were too much for many regular practitioners. The response was probably a significant factor in his resigning from the editorship of the 'British and Foreign Medical Review' in 1847. However, this did not hinder him receiving an honorary D.C.L. from Oxford University in 1852 and a Knighthood in 1853. So his status loss was only temporary.

The pusuit of purity, reinforced by stereotyped typification and stigmatization of homeopaths and homeopathy, tended to predispose some regulars to rather rash and ill-thought through acts. For example, the attempted suppression of the 1855 Homeopathic cholera statistics. These were a 'natural' extension of existing pollution-avoiding, purity-affirming responses that condemned any ideas and their 'carrier groups' which appeared to,or were assumed to,contradict, confuse or show as inadequate, cherished conventions. In other words:

"Uncomfortable facts which refuse to be fitted in, we find

ourselves ignoring or distorting so that they do not disturb these established assumptions".(64)

Given the above boundary - creating and - maintaining devices, a 'heretic' was always in the wrong once so labelled. Where the internal lines of acceptability were drawn, which the 'heretic' contravened, was contingent upon the differentials of power and the configuration of normative sanctions expressed in rules, regulations and ethical codes within the profession.

The general advantages of power domination and control weighted in favour of the regular profession, in its anti-homeopathic posture, made the conversion of some of its practitioners to homeopathy something of a social problem for them. Hence the production of the social machinery described above to contain, or eliminate, the problem by making the costs of conversion high. So what was involved in converting to homeopathy from regular practice? How was conversion maintained once it had occurred? These are the questions to which we shall now turn our attention.

6.4 Conversion

It has already been pointed out that the homeopaths were noted for:

"actively proselytizing for the cause of homeopathy,

seeking converts from among the ranks of the regular physicians".(65)

Given the differentials of power weighted numerically and institutionally - if not always legislatively - in favour of the regular profession, the deliberate conversion of some of them to homeopathy is striking to say the least. After all, to be born into a marginal social location - like being black or poor - is not something that is normally, deliberately chosen. To choose to become persecuted, stigmatized and outcast required considerable rationalization work to be done by regulars and homeopaths in order to explain it to themselves and the public. How the regulars dealt with that problem has already been described in the discussion of power and deviantization.

Conversion to an heretical medical system variously denounced as 'insane', 'immoral' and 'unscientific' by regulars requires some explanation. To this end three points will be made about it.

Firstly, that the typical reasons given for converting to homeopathy were those of conscience. This is not to deny that some may have 'emigrated' out of regular medicine for reasons other than eventual rejection of regular theory and therapy. There is no denying that most homeopaths could certainly earn more income than the

average regular practitioner. This could have provided sufficient attraction to some but it would not be regarded as conversion to homeopathy as here understood.(66) Secondly, that conversion, understood as a radical transformation of social identity, belief and in this case, medical practice, was costly to the convert in many different ways - socially, cognitively and affectively. Thirdly, that the reality and plausibility of conversion and its consequences for the convert have to be maintained by various mechanisms operating at social psychological and organizational levels of the re-socialization process. This latter phenomena will be considered in terms of the social and cognitive consolidation of the convert into a new social identity as a homeopathic practitioner.(67)

However, just before the main argument in considering conversion, its costs and benefits, two matters need to be recognised. First, the relevance, or otherwise, of T.S Kuhn's (1970) theorising about conversion in relation to paradigm conflict and incommensurability between paradigms.(68) Second, the practical matter of why regular practitioners would choose homeopathy rather than other non-regular practices.

6.4.1 Kuhn, Paradigms and Conversion

Kuhn's concepts of 'paradigms', 'normal science',

'revolutionary science' and their relationship in explaining the structure of scientific change were developed in relation to his historical investigations into what Ravetz (1973) calls the 'mature' (natural) sciences - physics, chemistry and biology.(69) Any attempt to directly apply Kuhn's theory to such an 'immature' occupational practice as applied medical science during the nineteenth century is highly contentious and probably doomed to failure at the outset, unless the theory is radically modified and made far more sociologically sophisticated.

This chapter's previous sections have presented the kind of theoretical issues which Kuhn tends to ignore. For example, he writes about dogma and authority in science education but has little concept of institutionalised differentials of power within a community of practitioners and the mobilisation of sectional interests behind the legitimating ideologies and rhetoric of science.(70) Neither does he adequately theorise about the nature of (scientific) revolutions in terms of the rapid de-routinisation of conventional practices and their replacement by 'new' ones which are both discontinuous and continuous with previous practices. Thus, on the view put forward here Kuhn's concept of revolutions as widespread, thoroughgoing periods of rapid change at conceptual, technical and normative levels of the scientific community, is fundamentally

misconceived. Revolutionary change is only one type of social de-routinisation of social and cognitive systems. In short, the cumulative nature of the proximate reproduction of social and cognitive practices is, during the so called 'revolutionary period', a similar proximate reproduction process as before but occurring over a shorter duration of time.(71)

His concept of revolutionary science provides the historical and conceptual rupture between two periods of normal science which are inherently incommensurable because each is ruled by different paradigms. Kuhn does not merely argue that each paradigm evaluates, investigates and interprets the '<u>same</u>' world differently but rather that, since paradigms are necessary to even think about and get around in that 'world', people with(in) different paradigms perceive different 'worlds'. Here lies Kuhn's second exaggeration. With his concern to demonstrate that there exist no neutral observation languages to mediate the terms of one paradigm to another, or to independently test them by, he becomes caught up in an obsession similar to that of the logical positivists/empiricists - but for inverted reasons - namely the reduction of meaning to logical concepts without remainder. Only, where the logical positivists used this technique to show theoretical equivalences of concepts at the level of meaning, Kuhn's object was to

show the impossibility of it because of incommensurability at that level of analysis.

The resolution of the presumed incommensurability of pre- and post-revolutionary paradigms has been made for all practical purposes, in two basic but similar ways. Firstly, Donald Davidson (1973) reduces the issue to one of the inter-translatability of language-systems by the construction of a dictionary of terms derived from investigative procedures of an anthropology of language-in-use. Conceding the point that there is no perfect correspondence between object-languages, none-the-less, for all practical purposes it is possible to translate one language into another, even through the medium of a third language-system if necessary.(72)

Secondly, Wittgenstein's solution, according to Derek L. Phillips (1977), is to mediate between speciality language-games by means of the basic language-game of ordinary, everyday life. Since all speciality and scientific language-games are grounded in the everyday language-game, they differ only in degrees of internal coherence, sophistication of conceptual machinery, reflexive technology (e.g. experimental test), range of explanatory power, degree of openness and closedness and so on.(73)

In discussing scientific revolutions Kuhn argues that

the conflict of paradigms (whether produced by pre- or post-revolutionary conditions) is not resolvable by appeal to a neutral observation language, since no such language exists. The world is and has to be interpreted and perceived from some perspective: a paradigm is such a perspective. That which enables a person to transfer their commitments from paradigm 'A' to paradigm 'B', which conflict, is a conversion - a process of rejecting one paradigm and accepting another - something which happens all at once.(74) However, conversion as a 'Damascus Road' experience is only one kind of conversion process. Conversion may take a number of years, as was the case with Ransford (1 to 2 years) and Holcombe (2 to 3 years). [See below at 6.4.3]. Neither is it the case that the person converting from one paradigm to another has to be totally committed to one or the other.(75) Following Wittgenstein it is quite possible, as Ransford and Holcombe did for a number of years, to learn to manipulate two language-games, two paradigms, two medical cosmologies with their universes of discourse and routine practices.

In the context of the conflict between homeopaths and regulars, those regulars who secretly experimented with homeopathy had to weigh the costs and benefits of publicly committing themselves to homeopathy or not. Many struggles must have occurred at the practical,

discursive and unconscious levels of the subjective 'dialogue' over the choice.(76) Eventually a decision was made to take up the status, role and identity of a homeopathic practitioner or not. Some incident may have tipped the scales one way or the other but, after due consideration, it was essentially a decision and a commitment made by the person. Conversion to a new paradigm may or may not involve a subjective (i.e. emotional) experience but it certainly involves biographical reconstruction, the taking on and consolidating of a new identity and the re-orientation of commitments to a new conceptual scheme, universe of discourse, medical practices, organizational objectives and social networks. In dealing with those aspects of conversion in what follows, the sociological/organizational and social psychological aspects of the phenomena will be described as well as making the important points that conversion is costly, generally non-arbitrary and susceptible to a reasonable explanation. In the light of the above contentions with Kuhn on conversion, paradigms and incommensurability the theorisation of conversion from an orthodox to a homeopathic medical cosmology has to be considered in the light of considerable sociological and social psychological literature on the matter.(77)

6.4.2 Why Convert to Homeopathy?

Even though this work does not directly investigate the question now raised we at least need to be aware of it. The question is: "Why should some conscience-stricken regulars choose homeopathy rather than the Botanic, Eclectic or any other non-regular system of medicine?" A solution to this probably lies in the kinds of social networks within which local practitioners operated and the frequency with which they came into contact with homeopaths, botanics, eclectics or others. The timing of those contacts within the biography and career of the regular would be important as to how seriously the alternative cognitive solutions they presented, in relation to his own personal and therapeutic doubts, would be taken. The kind of organization, its social status, career possibilities and other factors would be relevant in assessing the reasonableness of the choice made. However, the two main elements in the choice would appear to be (a) how well the chosen system resolved the existentialities of personal and professional doubts and (b) the quality and valuation of social relationships with representatives of the particular alternative medical system(s). This of course would involve considerable work on biographies of known converts, their field of social relationships (especially their contacts with non-regular practitioners

before and after conversion) and an assessment of the cognitive and organizational advantages offered by the chosen medical system compared to alternative ones available. However, that is worth its own independent research which cannot be covered here, although I am aware of its relevance and the historiographical problems about the availability of such data. All that can be given here are broad indications of why homeopathy was the largest of those 'alternative' medical organizations, or movements, which attracted most of those regular practitioners searching for a more certain therapeutic system than heroic bludgeoning or clinical scepticism. (Bearing in mind that the question of 'objective' therapeutic efficacy increasingly resolved itself in favour of bacteriological medicine, such that by the 1890's the homeopaths looked more and more like a stagnant, even degenerative, therapeutic system, judged by its lack of theoretical and empirical novelty or innovation). The 'professional' quality of the practitioners of homeopathy, the quality of their clientele and hence the incomes which could be made were all attractive features of homeopathy as an occupation.(78) To some it appeared more systematic and 'scientific' than regular therapies. It seemed more effective than either heroic or sceptical therapeutics and it was able to assimilate basic bio-medical disciplines into its theoretical structures to enable more effective

diagnosis and therapy to be accomplished. These general features certainly proved attractive to many.

6.4.3 Conversion Stories

Regular practitioners such as Charles Ransford in Britain and William Holcombe in the United States of America present typical post-conversion testimonies as to their struggles to cast off what they later interpreted as the deep rooted prejudices of regular therapeutic theory and practice[79], usually in its heroic or neo-vigorous modes.

(i) Charles Ransford (1851)

Ransford was an Edinburgh-trained physician and surgeon and a member of several medical societies specialising in anatomical, obstetrical and surgical knowledge.[80] Having been a

"determined opponent of Homoeopathy and its disciples"[81]

he now took the opportunity to:

"give my reasons for thus changing my opinions and practice".[82]

In other words the conversion testimony was an apologetic to explain to his non-homeopathic friends and colleagues in Edinburgh why he had become a practising homeopath. It was an article which also functioned as a means of

consolidating his new identity as a homeopath; and an evangelistic tract in the form of a personal witnessing to the 'irresistable', 'overwhelming truth' of homeopathy which he now felt it his duty to 'resolutely defend' and 'diligently propagate'.(83)

Typically, he now reinterpreted his pre-conversion practice of denouncing homeopathy as "quackery, delusion and imposture", its investigators and practitioners as "knaves or fools"(84) as evidence of the collective 'credulity and characteristic obstinacy' of the regular profession.(85)

Ransford's direct contact with homeopathic practice came sometime during 1844 when he, and some Edinburgh specialists he consulted with, failed to successfully treat one of his patients (an Oxford student on vacation) of some kind of heart complaint. This case had been under Ransford's care for a number of years but none of the regular therapies of depletion, digitalis or counter-irritants worked. The student, unbeknown to Ransford, consulted a homeopath and his treatment had perceptible effects. When he discovered a homeopath was getting results he explained it away by claiming that some remedy had been given, unbeknown to the student, in the so called dilution.(86)

The standard explanations of homeopathic 'cures' by

recourse to matters of imagination, faith, mis-diagnosis, vis medicatrix naturae, diet and regimen were typically used by regular practitioners.

He moved to Alnwick, in Northumberland, in 1848 and when he met any advocate of homeopathy, "usually amongst the higher classes of society"[87], he gave them some anti-homeopathic literature to read. However, he began to notice an increase in the number of homeopathic hospitals and of patients advocating homeopathic treatments. Between 1848-50 these circumstances and experiences "coupled with the increasing want of confidence in the ordinary practice"[88] prompted Ransford to test homeopathy secretly. His resolve in this matter was encouraged by the friendships of the physicians, Andrew Combe and J.J Russell.[89] His doubts regarding regular practices were not relieved by his conversations with "many eminent practitioners"[90] (un-named). Nor did John Forbes' sceptical injunctions about regular therapy (heroic and clinical-hospital) of 1846 provide him with the security and certainty he sought in practising the healing art.

Whilst trying out homeopathic remedies, unbeknown to his patients and achieving favourable results, he communicated his findings to some non-homeopathic colleagues. They advised him:

"not to proclaim my 'perversion' (so they termed it) until a few more months should have passed away".(91) They offered this advice in the belief that his further experiences would produce counter-instances against the 'truth' of homeopathy. However, quite the opposite occurred and over an eighteen month period (up to about 1850) he became increasingly convinced of its 'truth' and efficacy. He realised that to publicly avow his commitment to homeopathy would be costly. Indeed, he was told by his regular practitioner friends that to do so:

"would be to take a step fatal to my reputation as a scientific physician".(92)

He finally decided sometime between 1850-51 that his own experiences and the "testimony of so many enlightened and honest men, professional and unprofessional"(93)

provided:

"irresistible evidence...facts upon facts, until an overwhelming array presented themselves..... I felt that the only honest course to adopt was the avowal of my belief".(94)

In so doing he was quite aware that it would:

"endanger my professional reputation, and separate me from all existing professional ties".(95)

Nonetheless, he felt that:

"I dare not relinquish those remedies, or the mode of administering them, which I found so efficacious..."(96)

He therefore advised his readers to do what he did: investigate homeopathy in practice. If they did, with the intention of arriving at the truth, they too would come to a firm belief in the certainty and superiority of homeopathy, in the cure or palliation of disease, over regular practice.

During the testimony of his conversion Ransford contrasts his ignorance and prejudices before his conversion with his post-conversion 'enlightenment'.(97) He also tried to answer the kinds of objections brought by regulars, like himself, to homeopathic doctrines and 'cures', by presenting himself as a typical,prejudiced,(ex-)regular who discovered that homeopathy worked and that the standard objections - wrong diagnosis, workings of faith, imagination, the healing power of nature - simply repeated the ignorance and mis-representation of the profession in regard to the homeopathic system. Concomitantly, by presenting his pre-conversion prejudices as typical and his post-conversion 'enlightenment' as typical, he also presented his convertability as typical, as something which could be accomplished by anyone in a similar situation. Paraphrased, his testimony was; 'If you have doubts about regular practice, like I had,

then don't ignore them. Put aside any prejudices you have against homeopathy because they are not founded upon reason or facts about it. Homeopathy offers the certainty you seek in medicine. Try it out by practice and experiment and then you will see that it works and is far superior to the old uncertain practices of regular medicine. By an honest search for truth and certainty in medicine you will discover that homeopathy offers and delivers both'.

(ii) William H. Holcombe (1866)

Converted to homeopathy between 1851-52, Holcombe finally wrote about his paradigm shift/gestalt switch some fourteen to fifteen years afterwards. He portrayed his pre-conversion situation as the:

"struggles of an ardent and inquiring mind, whilst emancipating itself from the bondage of authority and emerging into the light and liberty of truth"(98)....

as a typical experience. One which any of his readers might undergo. Hence, there is not only a proselytizing thrust to his essay but a pastoral one in terms of himself as a counsellor directing the (absent) counselee to the 'truth and light' he himself had found in homeopathy.

He had heard of homeopathy whilst a medical student and

his teachers dismissed it as "transcendental medical moonshine"[99] and "an atrocious imposition upon the credulity of mankind".[100]

From his post-conversion position his pre-conversion life as a medical student is probably over-typified when he says:

"Of course I believed every word they [sic. his teachers] said. I was not expected or taught to seek for truth, but to receive what my masters imposed on me as truth. They dogmatized - I accepted".[101]

However, given the conservative nature of medical education during the nineteenth century (and not just that century) and the authority of tradition within professional medical practice[102] there are obvious resonances with Kuhn's thesis about the dogmatism inherent in much of the educational and research functions of scientific disciplines.[103] Sociologically this is interpreted as the transmission of scientific conventions and culture.[104]

He began his practice with his father, who was somewhat of a therapeutic sceptic. However, the spread of Asiatic Cholera from the eastern seaboard in 1849 triggered off something of a conceptual crisis for Holcombe. Regular therapies used against the disease varied from practitioner to practitioner and all were equally useless

as far as he could see. This threw him "into a sceptical phasis of mind. I became quite disgusted with the practice of my profession".(105) The success of homeopathy in this epidemic motivated him to investigate it to see if there might be something in it.(106) However, he began to learn about it, not from Holmes, Hooker or Hahnemann, but by buying a domestic kit of homeopathic remedies for treating cholera in its different symptomological phases.(107) He did begin treating a cholera victim homeopathically but sent for some 'allopathic' remedies just in case the homeopathic ones failed.

However, temporarily suspending the routine practices of regular medicine caused him great anxiety; for he says that:

"The spirit of allopathy, terrible as a nightmare, came down fiercely upon me, and would not let me rest. What right had I to dose that poor fellow with Hahnemann's medical moonshine, when his own faith, no doubt, was pinned to calomel and opium, and all the orthodox pills, potions and porridges!"(108)

He experienced a great relief when his patient recovered and had a rapid convalescence. It was this 'success' which began to consolidate a belief in homeopathy as a healing art:

"I was delighted: a burden had lifted from my heart -

a cloud from my mind. I began to believe in homeopathy".[109]

However, it took two years before his final resolution to follow homeopathy as a system came about 1851. In 1850 he moved to Cincinnati and because he established relationships and a position all in relation to the regular medical profession there his practice of homeopathy declined. He recognized what it would cost him in terms of the honour, good opinion, learning and respect he received from his friends and colleagues within the regular profession. At this point in his life he was not prepared to pay the cost of declaring his homeopathic leanings.

Stemming from a visit he paid to an uncle in 1851 he returned to Cincinnati inspired by "a new air, a new spirit, a new liberty"[110] from his holiday "in the vast solitudes of nature".[111] It was whilst journeying back to Cincinnati, on the steamboat, that the event which precipitated his public commitment to homeopathy occurred. There was an outbreak of cholera amongst the passengers and the clerk of the boat provided Holcombe with a chest of homeopathic medicines. Holcombe decided "to make a grand homoeopathic experiment"[112] and treated thirteen cases homeopathically. Not one died. On docking at Memphis two regular practitioners examined his cases with interest but immediately snubbed him on

learning he had treated them homeopathically. His experience with the cholera victims and his rejection by the two regular practitioners seems to have been the precipitating incident in his positive contact with homeopathy since about 1849 and he began studying homeopathic works, including Hahnemann. He also tested homeopathic drugs upon himself and made contact with local homeopathic physicians.(113)

The death of a lawyer friend of Holcombes, who charged him not to treat him homeopathically, finally turned him away (he said) from regular medicine. Even calling in Dr. Daniel Drake and Professor John Bell of Philadelphia failed to cure his friend. He felt no disrespect towards Drake and Bell and they treated him with every professional courtesy but Holcombe decided that:

"having seen allopathy practised in a long and painful case, in the best manner and spirit, by its best representatives, I determined to abjure it, as a system, for ever".(114)

This did not mean he rejected all regular therapies, only that he now rejected the system of thought and practice of which they were only a part. Individual therapies from regular medicine could still be employed in a practical way within the homeopathic framework when used homeopathically.

6.4.4 Conversion Accounts: Some Theoretical and Empirical Caveats

The above conversion stories reveal more about the typification of conversion and the convert as typically convertible in order to portray such an 'experience' as one which can be experienced by any 'normal' person. They are in fact biographical reconstructions made from a post-conversion position, yet they still contain sufficient incidental evidence to outline the historical contingencies of the conversion process.

The 'career' towards conversion is presented as a typical experience in both texts and can be understood as a remembering of the moral passage from 'normality' to 'deviance', or from ignorance to enlightenment - depending which perspective is taken as the evaluative bench mark.(115) Sociologically, pre-conversion biography is re-interpreted (from a post-conversion location) as the 'dark ages' of the convert's medical experience which leads to the moment(s) of 'enlightenment'. Post-conversion biography is interpreted as flowing from the converts new 'reality' qua homeopathy, as the period of true enlightenment:

"the biographical rupture is thus identified with a cognitive separation of darkness and light".(116)

The historical exemplar of such radical transformation

of belief and identity is that of religious conversion. As such, only within the community of homeopaths could conversion and its consequences be sustained as a continuing plausibility in relation to the re-directed commitments of the convert to professional homeopathy. Indeed the depiction of the conflict between the two medical systems as (not just as analogy) a struggle between two medical creeds, practices and faiths to live by comes out strongly in public and professional arenas of debate.

For example, in a discussion on how to remove the obstacles within the regular profession to the adoption of homeopathy, Mr.D.Macrae, a layman from Glasgow, writing in the British Journal of Homoeopathy, comments that:

"The writer's faith in homoeopathy (which has been confirmed by experience) was originally produced by the testimony of a fellow student. His faith (also remarkably confirmed by experience) was originally produced by the complete restoration of his mother under homoeopathic treatment, after being virtually given up by her allopathic doctors. She, also, had been persuaded to try it by a friend who had experienced and often witnessed its singular efficacy.

In fact, all believers in homoeopathy with whom he is

acquainted owe the first germs of their faith to the testimony of personal friends....he is not acquainted with a single person who has been induced to give homoeopathy a trial by published facts, far less by abstract reasoning....Our own impression is, that it is principally by vigorous personal advocacy that the knowledge and adoption of homoeopathy will be extended".(117) (emphasis added)

Whatever the limitation of the above author's experience of how people came to be converted to homeopathy and his quasi-religious understanding of its beliefs and practices, the sociological significance of the spread of homeopathy by means of friendship networks cannot be ignored. It is difficult to conceive of a more fundamental way for a medical reform movement, such as homeopathy, to ensure its diffusion, institutionalisation and hence its continuity. Articles such as the above, appearing as it does in a professional homeopathic journal, can be interpreted as being given a kind of professional 'blessing' upon the enthusiastic diffusion of homeopathic beliefs and practices by the 'laity' of the movement. Such a 'lay' version of 'scientific' homeopathy functioned as a 'folk-science'. That is, it was a quasi-religious, quasi-scientific popularisation of the homeopathic cosmology which functioned in terms of providing comfort, reassurance and a theodicy

regarding the crucial uncertainties and contingencies of the experience of death, disease and suffering, life, health and well-being, in categories derived from homeopathic discourse.(118)

The professional, 'scientific' homeopaths transposed such arguments into discussions about the ethical obstacles to improving relationships with regular practitioners in practical ways. For example, Alfred Pope (1861) a surgeon, recommended that in order to remove the ignorance of the regular profession regarding homeopathy:

"it is necessary that we so conduct ourselves towards our allopathic brethren professionally as to ensure so far as we can, obtaining a patient hearing from them.... and in replying to any of the numerous attacks made upon us, we should especially avoid all reference to the coarse, unmannerly, and unjust insinuations these so frequently contain"(119)

after all:

"Time was when the majority of those now practising homoeopathically practised and believed as do those of our brethren who are ignorant of the great therapeutic truths, a knowledge of which we have been permitted to receive. The remembrance of this fact should lead us to treat with charity the views and actions of those

with whom we once agreed, but from whom, owing to an increase of knowledge on our part to which they have not attained, we now very considerably differ".(120)

From a post-conversion position such a view is quite understandable as based upon a typified biographical reconstruction here generalised to the whole homeopathic community which sustains its continued plausibility. It seems clear that it is perfectly reasonable to interpret such articles about the improvements to, and impediments in the way of, professional relationships between homeopaths and regulars as also 'tracts' upon the improvement of 'evangelistic' methodology for proselytizing the regulars. They were 'evangelistic' in the sense that they encouraged practitioners to take the opportunities presented to them to 'witness' to the truth of homeopathy. They were 'methodological' in that general advice was given as to how to improve professional relationships and how to control (or create) the contexts in which opportunities to witness arose.(121)

Such a quasi-religious position on homeopathic belief and practice continued into the last quarter of the century even amongst professional, registered homeopaths.(122) Of course, not all professional homeopaths could go along with such an interpretation of their body of knowledge and therapeutic practices.(123)

They argued instead for homeopathy as a progressive science of medicine since improved physiological and pathological knowledge had had a definite effect upon homeopathic therapeutics and the classification system of their materia medica. The 'similia' principle, to the scientific homeopaths, was not so much a 'confession of faith' as a 'confession' of an empirically based natural law of cure:

"not the only one, but of the existing ones the most rational and sure".(124)

Some practitioners were opposed to the position which held that:

"Every inference drawn from the primary doctrine by its propounder, every theory he tacked on to it, and every practical application made of it" [was to be] "regarded as sacred truth".(125)

Thus, the professional homeopaths were caught in the contradictions created by their attempts to secure scientific legitimacy for their developing body of knowledge and practice, and the genuine motive - individual and organizational - to spread such knowledge and practice as widely as possible within the regular profession and outside it to gain public support for their attempt to reform orthodox medicine, or at least to improve its therapeutics. The fact that most of the

recruitment to the professional body of homeopaths was mediated by a 'conversion experience' which was naturally posed in a religious or quasi-religious mode of discourse, provided a natural bridge for further discourse to be posed in such terms. The importation of such terms, by transfer from the wider culture, is to be expected from a minority of practitioners whose historical development cast them as a sect within-and-outside the established 'orthodoxy'.(126) Their self-perception seems to have been analagous to that of the Protestant Reformers in relation to a 'corrupt' Roman Catholic Church during the sixteenth century.(127) Unlike the Reformers, however, the increasing 'scientification' of medicine eventually overtook the claims of homeopathic practitioners to greater therapeutic efficacy than their regular medical brethren. The raison d'être for homeopathy's claimed distinctiveness seemed to be of decreasing significance as the previous abuses of heroic therapy were corrected by the therapeutic scepticism of patho-physiological clinical medicine, (despite the resurgence of a neo-vigorous mode of therapy during the second half of the century). The innovations of chloroform anaesthesia (1847) and surgical asepsis (1860's-80's) helped to create the sense that medicine was safer and less painful. When coupled with the emerging scientific research programme of late nineteenth century bacteriological-

laboratory medicine any therapeutic novelty homeopathy could offer would hardly stand out against the quantity and quality of the advances in bacteriology, aetiological knowledge, tropical medicine, public health and so on.(128)

It is with these things in mind, that some of the existential costs and benefits of actual conversion can now be considered.

6.4.5 The Costs and Benefits of Conversion

In the context of the exercise of established medical power, mediated through the medical stigma conflicts of nineteenth century Britain and United States, being converted to homeopathy meant becoming labelled as deviant; immoral, irrational, insane and heretical.(129)

Transformations of identity from regular to homeopathic educated practitioner were not 'unnatural' when understood in the context of the societal wide transformations of nineteenth century industrial, urban, political and cognitive structures.(130) Such a process involved not only structural and cultural changes but also transformations in:

"sensibility, consciousness, reflexivity and cosmology - in short, the nature of personal and collective identity".(131)

Participation in homeopathic 'deviance' tended to follow from the nature of commitment to regular theory and practice which would sensitise the regular practitioner to internal anomalies and the perception of legitimate challenge from homeopathy towards 'orthodox' practices, such that some began to question its efficacy in comparison to homeopathy. This would sometimes escalate to a sense of ontological and therapeutic uncertainty about regular medicine. Given certain experiences with homeopathy and regular practice, problems with the former and the anomalies of the latter would be resolved, through conversion, into affirmations of homeopathy. The areas of contradiction would now lie with regular medicine since a switch in the rationale and rationality of medical thought had occurred. Such cognitive transformation necessitates a new socially constituted and reproduced plausibility structure to legitimate a new social identity as a homeopath. Such identity transformations are non-arbitrary and costly socio-cognitive and affective reorientation experiences which arise within the matrix of continuities and disjunctions present at the contingencies and intersections of biography, structure and cultural role models. Yet, however much conversion is a problem to the historical sociologist, it presents no such problem to the convert because:

"his experience is a solution to a problem".(132)

Conversion is both individual and social. It involves a turning from one 'reality' to another. It involves the mind, emotions, social relationships, values, commitments and the interpretive machinery for managing those realities and (re)interpreting their significance and meaning. Transformation can only occur when the formation processes of the previous 'reality' cease to be plausible. This occurs when individuals begin to press the normative and conceptual rules sustained by the inherent authority/power of their 'reality' beyond their capacity to exclude other 'realities'.(133) This is what happened when Ransford and Holcombe secretly tested homeopathic therapies on their patients and discovered they 'worked'.

The conversion experience brings about the emergence and resolution of three problems. First, the reconstruction and re-evaluation of individual biography; second, the creation, assumption and consolidation of a new identity; and third, the redirection of commitment to the new identity and its social location within the institutional arrangements of homeopathy as a collectivity.

(i) Biographical Re-construction and Re-evaluation

This process involves the dissolution, reconstitution and reinterpretation of past biography, career and sense of self-identity, in accordance with the new universe

of discourse provided by the homeopathic community.[134] This 'community' is rendered present by other, physically present homeopaths, forming the convert's new social network of colleagues and friends. It is also 'present' by the physically absent homeopaths whose 'presence' is mediated by homeopathic books, journals, other literature, and the anamnesis of present others about known absent others. Within such a 'community' - the physically present having primary influence - the new identity of the convert is constituted, consolidated and continuously re-affirmed.

Such biographical reconstruction is rendered reasonable by two basic re-evaluations. First, the convert's subjective understanding in past times is re-interpreted as a misunderstanding due to "the mists of prejudice",[135] "the bondage of authority",[136] or some alternative rationalisation. Second, as a consequence, the biographical rupture evoked by conversion often polarises the past and present as 'darkness' and 'light', respectively. Thus, since the post-conversion present functions as the locus of criteria for evaluating the validity and 'truth' about the past, biographical reconstruction often involves over-dramatization of the contrasts and discontinuities with that past. In this sense the negative evaluations of the past by Ransford and Holcombe, were probably over drawn, since converts

tend to exaggerate their pre-conversion sinfulness, ignorance and prejudice in order to increase the power and value of their conversion experience and their accounting of it in the mediums of communication. Such exaggerations, even fabrications at times, is not to suggest that deliberate, conscious deception is involved in such biographical reconstructions. On the contrary, the convert is simply and 'naturally' reinterpreting the past in the light of the post-conversion 'truth' which, necessarily, encompasses past and present. As such, a conversion text hardly presents an undistorted view of the pre-conversion past. Such a situation is hardly restricted to conversion texts either. All "biographies and identities are continuously redefined in the light of new experiences".(137) Historical phenomena and their reconstruction around a tacit, or explicit, problematic by the historian are products of the same kinds of processes. It is by means of his/her craft skill that the historian is able to approximate to the 'reality' of the problematic and an historical explanation and description of it.(138) In a very real sense then, the experience of conversion is the conversion of experience.(139) By such means - but not the only means (e.g. 'normal' learning processes) - the converts new identity is constituted and consolidated.

(ii) Constitution and Consolidation of Identity

The common experience of converts is not so much the conversion experience, the routes to it or developing from it but rather the experience of having to account for it, to themselves and others. By such an accounting the convert becomes involved in the constitution and consolidation of his new identity. The conversion stories of Ransford and Holcombe therefore, not only functioned as a means of typifying their own convertibility to the reader but also as a means of constituting and consolidating their own identities as homeopaths. In other words, the conversion story of the convert not only functions as a product and medium of the accounting procedures consequent upon biographical rupture but also as a proselytizing tool. Such activities not only consolidate identity but express the level of commitment to the beliefs and practices of homeopathy. Thus,proselytizing has the reciprocal consequence of not only learning to articulate a set of beliefs but also to internalize them more deeply.(140)

Important in the constitution and consolidation of a distinctive homeopathic identity was the erection of social and cognitive boundaries to set the group and self apart from the regulars. This entails an organizing of the group which is ideologically legitimated and generated. By means of a normatively sanctioned

entry mechanism regarding membership the convert can be directed into the approriate 'programmes' for the deeper appropriation, constitution and consolidation of his identity. This is often done by the institutional allocation of membership roles which clearly signal the convert's degree or type of commitment to the beliefs, practices and organization of homeopathy, as well as to his fellow homeopaths. For example, the British Homeopathic Society had five classes of membership. Inceptive members were medical students and qualified practitioners who were inquiring further into homeopathy but did not themselves practice it exclusively, as full members were required to do. Inceptive members were invited to reading sessions which dealt with the general philosophical and scientific foundation of homeopathic knowledge. Such sessions can be held to have functioned as mainly identity constitution sessions for the potential converts (i.e. inceptive members) and identity consolidation sessions for the full member giving the paper.(141) Fellows of the society were committed to homeopathy to the extent that they had been practising it exclusively for at least five years and had been in medical practice for at least seven altogether. Only the Fellows could elect the officers of the society, therefore ensuring that only demonstrably committed members could exercise executive power on behalf of the whole membership.

There was also membership of an honorary kind for retired practitioners and those in the auxiliary sciences such as physiology, anatomy, pathology and so on. This enabled those who were not in direct or continuing, exclusive practice of homeopathic therapeutics to signal their commitment to its basic philosophy. Corresponding membership was provided for practitioners outside the British Isles, signalling commitment to the international dimension of homeopathy. Lastly, since the local branches of the B.H.S. could only elect inceptive members it can be reasonably argued that proselytizing activities were de-centralised but that the symbols of commitment (signified by the kind of membership one had, length of practice and papers written) were hierarchical and centralised upon the metropolitan head-quarters of the society.

The boundaries of the homeopathic community (like their regular counterparts) were also continually being re-assessed by the intellectual 'gatekeepers' of homeopathic 'reality'. For instance there was consideration of the general relationship of medicine with philosophical and scientific developments[142] and the occupational implications of this for the ideological conflict between regulars and homeopaths.[143] Others considered the progress and status of homeopaths[144], whilst others considered its general effects upon scientific knowledge

as a whole.[145] Still others discussed the fundamental ideas of homeopathy[146] and its relation to auxiliary sciences such as pathology.[147] There was also concern about homeopathy's general state at various periods in its development,[148] as well as its relationship to the wider medical profession[149] and its constant battle for fair treatment from the regular profession.[150] Because homeopathy as an organization was involved in the above kinds of issues it would certainly influence individual self-conceptions, even if only in terms of opposition to them because of anxieties about their own internal purity of profession.

Since the homeopaths in the United States and Britain encouraged proselytizing activities it would at first sight seem to weaken group boundaries and challenge the distinctiveness of homeopathic identities. In fact it was more likely to operate as a reinforcement to individual identities and institutional separateness, since each act of 'witnessing' would consolidate and reconstitute the belief system more deeply in the cognitions and sentiments of the 'witness' whose psychic boundaries encompassed the community.[151] Such affirmation of identity, through proselytization, appear as important as its effects in increased numerical growth of the homeopathic collectivity. Clearly, for the homeopaths, increase in numbers reinforced their

belief in the veridicality of their knowledge and practices. However, although proselytizing activities are necessary to preserve homeopathy's distinctiveness, they are not sufficient to maintain its boundaries. The latter is discovered in their strategies and tactics of resistance to the attempts by regulars to control them by means of ideological stigmatization, cognitive elimination and varied forms of exclusion from professional intercourse.(152)

In conclusion, the key element in the constitution and consolidation of the new homeopathic identity was the degree of commitment the convert was able and willing to give to the new reality such that the:

"Degree of commitment may be viewed as the amount of personal identity ascribed to a given belief system".(153)

(iii) Commitment

Costs and rewards are involved in being part of any group. When the costs of belonging to a group outweigh the psychological and social advantages of commitment then the probability of the person leaving the group increases.(154) Sociologically, commitment is organizationally valuable since it can be channelled into a set of routine practices which contribute to the reproduction of homeopathy: proselytizing activities, writing articles and books (in fact the B.H.S.

required those eligible for Fellowship status to have been members for two years and have written at least two articles and a dissertation on homeopathy for the society), exclusive practice of homeopathy, membership of a local and/or national homeopathic medical society and so on.

Prior to conversion the regular practitioner is habituated to the authorities, knowledge and practices of the regular profession and confirmed in its efficacy and rightness by his colleagues and friends within it. However, as the conversion texts suggest, the contingencies of medical experience throw up various potential anomalies and if these include some experience of an apparent homeopathic 'cure' - either by a local homeopath, or by the converts own secret trial of some remedies - the psychic consequences can be painful. For example, when Holcombe tried out some homeopathic cholera remedies - secretly - upon a patient he said he felt:

"The spirit of allopathy, terrible as a nightmare, came down fiercely upon me, and would not let me rest"[155]...

but with the following 'success' of the remedy bringing him psychic relief and the beginnings of belief in homeopathy.[156] Allowing for some exaggeration due to biographical reconstruction in the post-conversion

situation, it is still reasonable to hold that Holcombe's routine commitment to regular medicine and his secret practice of homeopathy, would cause some cognitive dissonance and feelings of conscience (i.e.guilt). These would be induced by the normative constraints inherent in the regular position. Depending upon further similar opportunities to try homeopathic remedies the involvement with it may increase. Accordingly cognitive dissonance increases which is resolved in favour of regular or homeopathic 'reality'. The direction of this resolution,upon the valuation of such experiences within criteria of efficacy and adequacy, is initially derived from regular medicine but later modified by the experience with homeopathic remedies. Some would resolve their dissonance and anxiety (due to the clash of medical cosmologies) in favour of regular medicine because they considered that the psychic and social costs were too great. Consequently, it can be argued that a person's belief system <u>is</u> their identity. In addition,commitment to a medical system usually evokes and sustains a person's sentiments for and towards it. Thus, consideration of the possibility and option of conversion can be, literally, intellectually and emotionally painful for the potential convert, thus temporarily erecting a barrier to possible conversion. Such a barrier is sustained and constituted by the internal aspects of the medical cosmology to which

commitment has already been made.

Medical cosmologies include basic values (e.g. to be professional, scientific or gentlemanly); criteria of validity, adequacy and efficacy in order to evaluate the 'truth' of statements and experiences; internal rationale which connects beliefs into a network; conceptions of self and deviant others which circumscribe how believers differ from and relate to non-believers; substantive beliefs like similia, simples and dilutions; normative sanctions which regulate social relationships with other group members and non-members; and the organizational means to achieve valued goals (e.g. spread, or persecution, of homeopathy, monopolisation of medical market). These formal elements function to 'mesh' together believer, beliefs, practices and organization.

Conversion and commitment therefore, necessarily involve dissociative and associative processes.(157) The former encourage the potential convert to sever existing commitments to beliefs, practices and relationships which he previously valued. The latter encourages him to take an increasingly fuller participation in his new social relationships,their beliefs, practices and organization. Therefore, those commitment mechanisms which form and reinforce the new social identity,in order to increase commitment to 'being-a-homeopath', along with other

homeopaths, are: (a) a distinctive universe of discourse which in fact functions as the primary means of identifying potential or actual homeopaths. Indeed the talk and reasoning of the convert is the surest indicator of the radicalness, depth or otherwise, of the conversion experience;[158] (b) a distinctive set of medical practices, particularly therapeutics, which enables patients and other practitioners to distinguish homeopaths from non-homeopaths. However, this is not as sure a guide as a distinctive discourse since some practitioners may only be 'dabbling' in homeopathy to satisfy their own curiosity or as a concession to patient demands for such treatment. The only professional context in which homeopathic practices were likely to be empirically ascertainable would be that of consultation between a homeopath and a regular practitioner. Despite normative sanctions against such consultation it seemed to have been observed more in its breach than its practice, especially in metropolitan centres;[159] (c) proselytizing and 'witnessing' activities; (d) a new network of relationships within the homeopathic collectivity which gives 'objective' grounding for the 'subjectivity' of the new identity;[160] (e) routinisation of the passage from non-believer to believer in order to more effectively re-socialise the convert and allocate a recognized status and role within the organization (e.g.'inceptive member', 'full member' and

so on); (f) and the mobilization of authoritative and allocative resources to defend homeopathy from the attempts by the regular medical profession to control and eliminate them.(161)

In such ways the homeopaths maintained their continuity. By the recruitment of potential converts and their transformation into committed members, the integration of self-interest with the necessities of the reproduction of the knowledge, practices and institutions of homeopathy was secured.(162)

6.5 Summing Up the Margins

This chapter has developed an informal, descriptive theory of the political and historical sociology of medical marginalisation by extending the original Weber-Berlant thesis of monopolisation. In the light of the novel extension and development of this thesis, future considerations of the issue of medical monopolisation and occupational closure can no longer hold the historically and politically constructed phenomenon of 'medical heresy' as marginal to the proper understanding of the development of 'professional' or 'scientific' medicine.

The central issues of medical monopoly, heresy and marginality have been firmly located, as they should be, within wider considerations of power, ideology, occupational interests, deviantization and the reciprocal

nature of social control. The 'success' of 'mainstream' medicine in accomplishing monopoly and closure was not the product of inexorable social and scientific 'progress' but of the structuredness and contingency of the operation of human agency, individual and collective.(163)

Within the framework established, the problems and phenomena of conversion from an 'orthodox' to an 'heretical' medical cosmology were examined. This examination focused upon the typification of the experience of conversion as the fulcrum of the conversion of experience and the social mechanisms used to maintain the plausibility of the new beliefs and new social identity.

In the light of these issues, historians and sociologists of medicine can no longer ignore the fact of the ideologically constituted nature of terms such as 'orthodox', 'unorthodox' or 'heretical', 'mainstream', 'marginal' or 'fringe', 'regular' or 'irregular', 'scientific' or 'unscientific'. Such terms are descriptive and prescriptive at one and the same time. This is not to suggest they should all now be banned but rather that they should now be used critically and self-consciously. Historians and sociologists should be fully aware of their significance in the ideological mobilisation and legitimation of powerful sectional

interests within the occupation of 'professional' medicine.[164] For this reason the following epilogue will critically review some of the historians of medicine who have written extensively or commented upon the development of medicine in relation to 'marginal' medicine in general and homeopathy in particular.

CHAPTER SEVEN

EPILOGUE: A CRITICAL REVIEW OF HISTORIANS OF MEDICINE ON HAHNEMANN AND HOMEOPATHY

7.1 Introduction

This research has so far shown that the apparent 'facticity' of the boundaries between 'true' and 'false' medicine is actually the outcome of the contingencies and structuredness of the asymmetries of power between competing collectivities of medical practitioners attempting to maintain, extend or achieve a recognized location, status and legitimacy within the occupation of medicine and the wider social system. The notion that scientific knowledge is philosophically absolute and epistemologically pure (i.e. non-social) is no longer tenable since the construction of the 'new history and philosophy of science'.(1) However, the opposite and equal error of the sociological reductionism of scientific knowledge to nothing but the product of social forces and political interests must also be avoided. Indeed, the very dualistic model of science/ ideology has to be abandoned as no longer adequate to the theoretical and empirical tasks at hand in the history and sociology of medicine. It is not that scientific and ideological knowledge are different kinds of knowledge but that ideology is an aspect of all kinds

of symbol systems.[2]

From these general but implicit issues we will now move on to consider what a representative selection of historians had to say about Hahnemann or Homeopathy.

7.2 Johan Hermann Baas (M.D.)

In volume two of his two-volume work of 1889 entitled "Outline of the History of Medicine and the Medical Profession"[3], Baas claimed that homeopathy refused to recognise the existence of a 'vis medicatrix naturae', that homeopaths claimed "no disease could withstand it" and that as a result of its principle of similia in the selection of remedies "homeopathy, more than all other medical systems, produces the impression of reckoning upon the ingenious arrangement of deception and credulity of the weak-minded".[4]

He later comments that:

"For in the idea of the majority of the laity medicine still appears to be a mystical knowledge or a blind matter of experiment. In this the nineteenth-century is precisely like the Middle Ages - and upon the thoughtless assumptions and superstitions of both the educated and uneducated depends the success of homeopathy".[5]

My first comment is to point out that Baas is a

university educated regular physician who speaks from the vantage point of bacteriological medicine which was advancing and making fruitful, applicable, novel discoveries at the time. He takes his view of Hahnemann and homeopathy from a Dr. Bakody, a homeopath, who made some significant modification to Hahnemann's original position and adapted it to the more psychologically orientated medicine of the second half of the nineteenth-century. It is likely that Baas' own medical education included some ideologically slanted, negative evaluation of homeopathy which his historical work did not overcome in the slightest.

It is just not true to say that the natural healing power of the body was denied by homeopaths, only that it may require the assistance or intervention of the homeopathic physician at times.(6) This was also the position of many regular practitioners.

The use of the vocabulary of insult - 'deception', 'credulity', 'weak-minded' is in contrast to that of the self-congratulation of "the experience of sensible men"(7) and the results of "reasonable observation and thought"(8). Such polarisation reproduces the ideological barrier between what Baas saw as the Good and True medicine of orthodoxy and the Bad, Irrational medicine of homeopathy. It can hardly be said that he brought a dispassionate, academic professionalism to bear upon

the empirical data of nineteenth-century medicine in relation to homeopathy.(9)

7.3 Fielding H. Garrison (A.B., M.D.)

In his 'positivistic' and whig magnum opus of 1917, "An Introduction to the History of Medicine; with medical chronology, suggestions for study and bibliographic data" (10)

he gave nearly a page and a half to Hahnemann and homeopathy but judged it to be sectarian quackery. He provided some legitimating quotes from Flexner and Robert Morris along with some references to medical impostors such as John St. John Long and non-orthodox practices such as osteopathy, chiropraxis, Christian Science and eclectic medicine.(11)

Of Hahnemann and homeopathy in particular he said that it was one of the "many isolated theoretic systems of the preceding century,(12) yet failed to point out that this isolation was something accomplished by the anti-homeopathic, heroic, regular practitioners in their rejection of homeopathy as legitimate medicine. He stated the distinctive homeopathic doctrines of the Similia, infinitesimal doses and the Psoric theory of chronic disease, were all to be found in the 'Organon' of 1810.(13) He is incorrect on several counts. First, Hahnemann's basic formulation of Homeopathy is to be found in his 'Organon' but his later theory of the

Psoric origin of chronic disease was actually published eighteen years later, in 1828, as Chronic Diseases: their peculiar nature and their Homeopathic Cure, which did not gain much support from later generations of homeopaths. Secondly, although Hahnemann recommended diluted homeopathic remedies he did not, until later, begin to recommend extremely high dilutions in later editions of the 'Organon'. Third, Garrison mistakenly regarded the 'Similia' concept as simply a:

"revival of the old Paracelsian doctrine of signatures, namely, that diseases, or symptoms of diseases, are curable by those particular drugs which produce similar pathologic effects upon the body".(14)

Yet examination of this Paracelsian doctrine, which he describes earlier in his book(15), actually shows it as nothing like Hahnemann's iatrochemical interpretation of it. Paracelsus' doctrine referred to some physical resemblance between the remedy and the diseased organ, or symptom. Perhaps he would have omitted to make such elementary mistakes if he had actually read primary homeopathic documents rather than rely upon the work of Professor Max Neuberger's assessment of Hahnemann and homeopathy in the "Puschmann-Handbuch", Jena 1903, vol. ii, p.125-129.(16)

7.4 Douglas Guthrie (M.D.)

This work of 1945, "A History of Medicine"[17] was positivistic in a similar sense to Garrison's. In his chapter on Eighteenth-Century Medicine[18] he discusses the animism of Stahl, the vitalism of Joseph Barthez (1734-1806), the etherialism of Frederich Hoffmann (1660-1742) and the animism and vitalism debate. Under 'Doses - large and small' he mentions John Brown (1735-88), and Samuel Hahnemann. Correctly reporting the basic tenets of homeopathy as the Similia, single doses, dilutions and potency, he does give a positive comment that:

"Setting aside the value of his deductions, Hahnemann added greatly to our knowledge of the action of drugs"[19]

but soon follows it by glowing comments about the above-named 'regular' (?) practitioners, as he turned to the 'heroes' of the development of medicine such as Herman Boerhaave (1668-1738), William Cullen (1710-90), Albrecht von Haller (1708-1777), Gerhard van Swieten (1700-1772), Sir Robert Sibbald (1641-1722), Dr. Archibald Pitcairne (1652-1713), the Munro's, Charles Aston, Francis Home (1719-1813), Robert Whytt (1714-66), James Gregory (1753-1821), John Pringle (1702-82), James Lind (1716-94), Wm. Cheselden (1688-1752), Percival Pott (1714-88), John Hunter (1728-93), Bichat (1771-1802),

Matthew Baillie (1761-1823), Edward Jenner (1749-1823) and others whom he valued as the true precursors of modern medicine. He said of Hahnemann and those he judged to be like him:

"It is a relief to turn from these theorists and extremists to those who were content to make the best use of the existing knowledge, and to devise methods of teaching which would yield the best results in medical practice".(20)

His list of precursors of modern nineteenth-century medicine were all orientated in the direction of the basic medical disciplines of surgery, physiology, pathology and anatomy rather than pharmacological therapeutics, which was much more difficult to establish upon an objective basis. Thus, his history of medicine is ordered in line with the linear, cumulative, 'progressive' historiography of modern medicine and homeopathy regarded as an extremist aberration. Such an evaluation costs little when made from the politically and socially triumphant occupational position of professional, university trained doctors, of which fraternity Guthrie was a member. This is not to necessarily invalidate his evaluations of homeopathy but it is to point out that his evaluations are not accidental to his occupational socialization.

7.5 Richard Harrison Shryock

Shryock's work of 1948 entitled "The Development of Modern Medicine"[21], marked a new development in the history of medicine. It was much more aware of the social aspects of the development of western medicine and began its story from the scientific 'revolution' of 1600 in the physical sciences, with the emergence of scientific knowledge as mathematical and experimental. Yet, he completely misses out the years 1850-70. He deals with the emergence of modern science, 1800-1850, including an aside to Homeopathy,[22] the rise of medical sects, and the loss of public confidence in regular medicine.[23] He then leaps to the beginnings of the bacteriological research programme, 1870-1900, missing out the details of the 1850-70 period in Britain and the U.S.A., except to comment that it saw the introduction of asepsis and antiseptic techniques by Pasteur and Lister. Yet these were hardly advances in therapeutics as such. Rather they were a set of methods applied in surgical situations to reduce the necessity for post operative therapeutics, as well as making such operations safer and painless.

Shryock argues that the critical empirical checking of homeopathic claims forced it out of regular, mainstream medicine. Being a product of German 'naturphilosophie' it was monistic in its pathology and therapeutics. The

rise of empirical, clinical medicine reduced it to the status of a medical sect rather than a system.(24)

On the contrary, the rise of empirical, clinical medicine produced medical scepticism, even nihilism, in therapeutics and most empirical advances were taking place in surgery, pathology and anatomy, rather than pharmacology and therapeutics which he admits much later on in the book.(25)

The empirical, critical checking of homeopathic claims just did not occur, when they did occur, under controlled conditions satisfactory to homeopaths. Since they both used similar criteria of efficacy there was no way that regulars could claim superiority. If judged against the statistics produced at the time, the homeopaths seemed to be more 'successful' than either heroic or sceptical therapeutics as far as patient recovery from illness, or survival of the therapy, was concerned.(26) He argues that...

"this transfer from the status of a system to that of a sect affords one of the best criteria for dating the final advent of modern medicine. When a monistic pathology and a related therapeutics were no longer tolerated in regular medicine, that medicine has come of scientific age, Since that day, the same social and psychological factors that encouraged the eighteenth-

century systems have continued to support essentially similar modern sects, each with its one cause and one cure - hygeists, chiropractors, Christian Scientists and the like - but a more critical science no longer affords them recognition".(27)

Such a position actually uses sociological criteria to indicate the 'scientificity' of modern medicine, notably the emergence of a community of 'scientific' practitioners able to establish certain criteria as the proper conventions to use in judging the worth and veridicality of all truth claims. It also gained the social status and power to enforce such a general set of criteria. However, just what does he mean by the term "regular medicine"? For most of its existence 'regular medicine' was a pluralistic set of competing monistic medical dogmas and associated practices. Homeopathy never claimed to advocate 'one cure', it advocated many specific cures for specific symptomological complexes. It only advocated the 'Similia' as the single greatest methodological principle of drug selection but not as the only one. It was simple to understand and its positive heuristic extended pharmacodynamic knowledge of drugs along more accurate lines.

Shryock's sources, for his position on Hahnemann and homeopathy, are the 'Organon' and various publications

by anti-homeopathic, regular practitioners such as Oliver Wendell Holmes. Other than that, there is little evidence of investigation of the primary documents advocating or criticising homeopathy. Neither does he seem to realise that monism can operate at various levels of medical thought, not just at those of pathology and therapeutics. Together with the style of a medical system it can shape the overall perspective of a medical cosmology. For example, the medical cosmologies of Heroic-Bedside, Clinical-Hospital and Bacteriological-Laboratory Medicine all exhibited a certain dominant, single minded style of theory, practice and eventually systematic research.

Although presenting an innovative social history of medicine, Shryock is still the victim of professional ideological judgements implicit in some of the evaluations he makes of homeopathy. Judgements which assume the unambiguous empirical refutation of homeopathy, its implicit sectarianism and the scientific maturity of regular medicine in rejecting homeopathy 'way back then'. He seemed not to realise that his anti-homeopathic interpretations of medical history were typical ideological products of regular medicines' conflict with homeopathy during the previous century.

7.6 Lester S. King (M.D.)

In his "The Medical World of the Eighteenth Century" published in 1958 and reprinted in 1971, Dr. Lester S. King devotes a whole chapter to Hahnemann and Homeopathy called 'Similia Similibus'.(28) He assesses Hahnemann's medical innovations as exhibiting:

"Profound scholarship that lacked common sense. Penetrating intellect that could not see the obvious. Great logical acumen that ignored facts" (29)

and that he regarded the actual system as having been demolished, time and again, by Oliver Wendell Holmes, M.D. and Worthington Hooker, M.D. in the United States, and James Young Simpson, M.D. in Britain.

He further comments that...

"Homeopathy, as a doctrine, stems directly from the personal life of Samuel Hahnemann" (30) (emphasis added) and that because of his period of wandering and translation work, (1779-1805):

"Hahnemann did not have a very active medical practice... ... In part, therefore, the numerous extravagances in homeopathy arose from Hahnemann's lack of experience with patients".(31) (emphasis added)

Two comments on his evaluations will suffice. First,

the debunking genetic evaluation of Hahnemann's doctrines as deriving directly, therefore arbitrarily, from his 'personal life', only carries weight if he ignores the (cautious) epistemological statement that the validity of propositions is not undermined by the social and psychological conditions of its discovery. Thus, King commits the genetic fallacy. Alternatively, if he presupposes the invalidity of homeopathic doctrine as an a priori epistemological position of his historiographical evaluations, then it follows that homeopathy will be (and is) interpreted as a peripheral aberration or error in the positive history of medicine.

Second, it is difficult to empirically sustain the assessment that Hahnemann had a 'lack of experience with patients' which significantly contributed to the 'numerous extravagances in homeopathy'.

If we take the period of his life from the start of his medical education in 1775 at Leipzig University, to the publication of the 'Organon' in 1810, the following pattern emerges -

1775. Enters Leipzig University Medical Faculty.

1777. Moved to Vienna University for two years in order to gain clinical experience.

1779. Qualified as M.D. at Erlangen, the 10th. of May.

1779-96. Wanderings and Translation Work.

1780. Practice at Heltstedt, a mining village. (1 year).

1781. Study of experimental pharmacology-chemistry with Herr Hasler in the Moor Pharmacy at Dessau. (2 years).

1783. Practice as a locum for the Medical Officer of Health at Dresden. (6 years).

1789-96. Translations of various medical works.

Criticism of heroic bleeding of Emperor Leopold the IInd. by regular physicians.

(1796) Essay on a New Principle published in Hufeland's Journal.

1797-1810. Conflict, Experimentation and Practice.

1797. Attacked by apothecaries at Königslutter for compounding homeopathic remedies, (intermittent practice).

1799. Involved in combating a European epidemic of scarlet fever. (2 years).

1805. Publication of "The Medicine of Experience" in Hufeland's Journal.

1805-10. Six years of further self experimentation with homeopathic medicines.

1810. 'Organon'.

So he had at least two years clinical experience, a years experience of experimental chemistry, seven years of translation work, six years homeopathic experimentation,

and nine years 'general practice'. It seems to me, that at least nine years practice, two years clinical experience and six years homeopathic trials, hardly constitutes a 'lack of experience with patients' as King claims. He does, however, admit that Hahnemann was on sound methodological ground in pointing out the important practical difference between results of drugs 'in vitro' and those 'in vivo'. Also that the results of animal experimentation was not of great validity compared to 'in vivo' experimentation upon live human beings.(32)

He also wisely concedes that -

"the superiority of regular medicine over homeopathy was not self-evident"(33)

nor could it be, given the immature state of experimental therapeutics in the medical faculties of European universities; with their concentration upon pathology, anatomy and physiology. He may be willing to admit that:

"Nor is it helpful to demonstrate the absurdities of homeopathic doctrine, if allopathic medicine cannot conclusively demonstrate its practical concrete superiority".(34)

But he can only establish a negative case for regular

medicine when he says that:

"Allopathic errors do not establish the truth of homeopathy".(35)

All very judicious statements about the limits of regular medicine but really emphasising the faults and failings of homeopathy. His final position regarding Hahnemann and homeopathy is that:

"he was reasonably successful, not because his doctrines were true, but because he battened on the decaying parts of regular medicine, upon the errors and stupidities which opponents committed..... Error thrives because truth is not sufficiently self-evident".(36)

This assumes the inherent and intrinsic falsity of homeopathy whilst avoiding saying the virtually unthinkable to a medical historian trained in regular medicine and committed to the ideological, historical mythology of the profession. The unthinkable is that homeopathy may have actually been a better therapeutic system than heroic or sceptical therapeutics and the regulars just couldn't literally and ideologically afford to admit that. This is not to deny that Hahnemann did not make any logically dubious, even false deductions and naïve conclusions but those were flaws characteristic of his critics also. Take, for example, the whole conceptual apparatus erected to

justify and legitimate the practices of bleeding and purging.(37) In the context of regular medicine and its practices, for King to assert that Hahnemann "battened on" its "decaying parts" is a post hoc ideological defence of it. It ignores the fact that the actual practice of regular therapy was grossly immature for virtually all of its known history, even during much of the nineteenth century.

The homeopathic claim to scientific legitimacy has not been objectively demonstrated by homeopaths or objectively refuted by its critics on the basis of agreed experimental methodology and agreed evaluative criteria. Yet access to financial resources from government medical bodies has been constantly denied on the basis that homeopathy is 'unscientific' by (ideological) definition. This indicates the deep ideological shaping of the history of medicine and its outcomes in contemporary policy regarding medical research.

7.7 Martin Kaufman

"Homeopathy in America: the rise and fall of a medical heresy" by Kaufman in 1971, is the product of Ph.D. research originating from Johns Hopkins University, by far the exemplar of modern 'scientific' medicine in the United States.(38) This was followed by his work of 1976, "American Medical Education: the formative

years 1765-1910" which has a different tone and conclusions to come to.(39)

Kaufman's work is an excellent historical study of, as his sub-title suggests, "the rise and fall of a medical heresy". (emphasis added)
First, I will correct an inaccuracy which medical historians, such as Kaufman, have tended to reproduce. This is that the Homeopaths coined the term 'Allopath' to apply to the regular profession and that its meaning implied that they practiced according to ANY theory. This is quite wrong. The term 'allopathy' was coined to contrast the homeopathic principle of "similia similibus curantur" (like cures like) with what they considered to be the principle upon which allopaths implicitly practiced, that of "contraria contrariis curantur" (unlike/dissimilar cures unlike). In other words, homeopaths claimed that regular (particularly heroic) practice principally consisted in using remedies which:

"either produce effects of an opposite nature to the symptoms of the disease (f.i. purgatives for costiveness, astringents for diarrhoea)..... or which gave rise to phenomena altogether different or foreign (neither opposite nor similar) to those of the disease (f.i. a blister for sore throat; derivative method, counter irritation)".(40)

Second, his sub-titling of homeopathy as a heresy (objective fact?) is pejorative, to say the least. So what we have is not quite the dispassionate or even ideologically self-aware history it appears to be and could have been.

In his concluding chapter, he charts the continuing decline of homeopathy from the end of the nineteenth-century. He correctly interprets this as being drastically hastened by the effects of Flexner's report and its enactment by the medical colleges and the A.M.A. from 1910 onwards. With the failure of the American Institute of Homeopathy, in 1950, to persuade the A.M.A. to accept homeopathy as a therapeutic speciality under the American Board of Internal Medicine, the virtual end of homeopathy was in sight. The A.M.A. refused to accept homeotherapeutics as a speciality within orthodox medicine, but it was prepared to consider it as a speciality under the Institute's control. Thus, although, in terms of substantive content of the education and training of homeopaths, there was little difference between it and regular medicine (even though the similia of therapeutic methodology was held to by A.I.H. homeopaths) the homeopaths failed to gain the professional legitimacy now monopolised by clinical and bacteriological medicine.

Kaufman concludes by claiming that homeopathy was not

likely to survive into the 1890's as a distinctive therapeutic practice because of (a) the stagnation of its knowledge and practices; (b) rising standards of medical education; (c) public dislike of medical sectarianism; (d) effects of medical specialisation; (e) general materialistic philosophy of Americans in contrast to the idealist philosophy of homeopaths; (f) its inability to cope with the patient work-load of modern practice; (g) and its inability to provide quick 'seeable' results for patients. This is quickly followed by the assertion that osteopathy seemed to be repeating the historical developments of homeopathy, with merger, internal strife and moves to preserve its distinctive identity being apparent.

The concluding paragraphs[41] to my mind are an interpretive key to the whole work. What seems to be offered is an excellent history of the rise and fall of homeopathy in the United States <u>but</u> with a moral 'punch-line' at the end. This seems to interpret the history as a rather detailed Aesop's Fable aimed at other 'irregular' medical groups like osteopaths, chiropractors and so on. The message to them being: "If you don't make your peace with the regular medical profession, particularly the A.M.A., you will virtually disappear. You can't win the fight. The homeopaths, the most professional and well educated of all such

groups during the nineteenth-century, tried and failed. So what hope do you others have? None!" Contemporary integration of osteopathy under A.M.A. control would seem to bear the proposition out, but other 'irregulars' are resisting rather aggressively.

My final comment upon this particular work is that, although it is an excellent history of homeopathy in the United States of America it is uncritical of the ideology of the 'regular' medical profession in relation to 'irregulars' in general and homeopaths in particular. As we have seen, such terms are historically and politically constituted within the 'programme' of professional monopolisation and the consequent marginalisation of 'unorthodox' competitors.

These criticisms, although they may not be fatally damaging ones, are <u>significant</u> ones. Kaufman modifies my initial charge of ideological naïvety in his work of 1976 on the history of American medical education between 1765 and 1910. Although he is more explicit about the deep seated faults and failings of the 'regular' practitoners he still seems to assume the inherent legitimacy of that particular collectivity of 'professional' practitioners to veridical status. Thus, for him, only that strand of medical tradition can rightly claim the title of 'professional, scientific medicine'. Yet, resisting his own ideological

seduction about the development of 'regular' medicine, he does concede that orthodoxy was pretty 'bad' medicine for quite a time. He rightly states that:

"Heroic medicine undoubtedly contributed to the high mortality rate of the day" and it was "safer to treat oneself than be tended by a [heroic] physician".(42)

He also admits that:

"The scientific claims of homeopathy have never been submitted to objective, unbiased examination; rather they were cast aside by orthodox practitioners as being too ridiculous to merit serious study".(43) (emphasis added)

He is not prepared to admit,that it was not just better to treat yourself and avoid calling in the heroic physician, but that it was probably better to call in a homeopath than either the heroic practitioner or just treat yourself. This is avoided because homeopathy was reduced by regulars to being equal to or worse than no treatment at all and most historians of medicine have continued in this ideology.

He also places the scientification of medicine and the beginning of effective and widespread reform of medical education as following upon the Bacteriological Revolution of the 1870's.(44) This helped create a 'neo-

orthodox' medicine with more confidence in the effectiveness of its innovations in therapeutics after the 1890's. A welcome change from the therapeutic scepticism of regular practitioners during the previous thirty years or so. The rise of Bacteriological-Research based medicine, together with more effective reform of medical education, was the beginning of the end for homeopathy. As a totally independent medical system homeopaths claimed, many times, that their therapeutic practices were statistically much better than those of heroic, neo-vigorous or clinical (but sceptical) medicine,(45) before the bacteriological research programme began in real earnest. However, even that did not deliver a successful mass therapy (diphtheria antitoxin) until the 1890's, whilst Osler was still practicing his clinical scepticism.

One wonders whether Kaufman's move from the Johns Hopkins University Press, after his 1971 work, to a completely different publisher for his 1976 work, is not unconnected to his more critical tone towards the 'regular medical profession' and the few critical concessions he makes towards homeopathy. Yet he is still not able or prepared to concede that for much of the century homeopathy was probably a 'better' system of medicine over heroicism and scepticism/nihilism.

7.8 W.G. Rothstein

With Rothstein's work of 1972, "American Physicians in the Nineteenth Century: from Sects to Science"[46] we are faced with a monumentally detailed and exacting study of the scientification of professional 'regular' medicine. Compared to all the previous historians he is quite explicit about his theoretical, methodological and ideological framework of historical and socio-logical analysis.[47] The object here is not to engage in a detailed study and critique of his model of socio-historical analysis (interesting and rewarding as that may be), but to actually see what his evaluations of Hahnemann and homeopathy are. If they have specific links with the way his analytical framework constrains interpretation and evaluation, then these 'biases' will also be indicated.

Notwithstanding the above, what is Rothstein's assess-ment of Hahnemann and Homeopathy? This he elucidates, in detail, in two chapters. One on the rise of homeo-pathy in America from 1825 to 1847 and its origins with Hahnemann in Europe. The second on the formation and eventual demise of Homeopathy as a medical sect from the 1840's to the end of the nineteenth-century.[48] The first of these chapters is of greater importance to my present interests.

He accuses Hahnemann, in the 'Organon', of proposing the theory of dilutions on the basis of...

"one empirical finding, performing some deductions, and stating a number of wholly arbitrary rules about drug action".(49) (emphasis added)

This ignores the fact that Hahnemann's empirical findings, in 1790, with the effects of cinchona bark, was actually followed by six years of pharmacodynamic experiments upon himself, and others, to test its efficacy and those of other remedies before he published his "Essay on a New Principle" in 1796. This was followed by a further fourteen years of attempting to formulate and exercise a medical practice on homeopathic principles. Hahnemann battled the apothecaries who tried to stop him compounding and dispensing his own drugs and involved himself in the Scarlet Fever Epidemic of 1799. He then wrote his theory and practice of homeopathic medicine, the 'Organon', published in 1810. So, in fact, twenty years had passed between his crucial experience of 1790 to the emergence of the basic homeopathic system in 1810. Hence, I find such an assertion impossible to sustain against the historical data available.

He further says that...

"In his eccentric fashion, Hahnemann made one of the

great discoveries of his time: he established that, given the existing state of medical knowledge, the absence of therapy" (he means homeopathy) "was vastly superior to heroic therapy. The fundamental soundness of his perception is clearly manifested in the positive and negative hygienic and therapeutic measures that he advocated: he accepted the medically valid therapies of his time, and he recommended the use of fresh air, bed rest, proper diet, sunshine, public hygiene and numerous other beneficial measures at a time when many other physicians considered them of no value. He opposed bloodletting, blisters, large doses of drugs and the whole host of heroic therapy. Unfortunately, Hahnemann misinterpreted his great discovery, and attributed his success not to drugless therapy, but rather to his homeopathic doses. Nevertheless, Hahnemann's total therapeutic system was a marked advance over the heroic therapy of his contemporaries".(50) (emphasis added)

Rothstein's equation of homeopathy with absence of therapy is in point of fact a post hoc evaluation of homeopathy which ignores his earlier discussion of the evaluation of the validity or non-validity of medical therapies in which he says that:

"Early in the nineteenth century, there were few medically valid therapies, but after the middle of the

century, major discoveries which were made in the many areas of medical science augmented the physicians ability to treat his patients effectively"[51] (emphasis added) and that "medical knowledge was limited and unscientific during much of the nineteenth century".[52] (emphasis added) He is not prepared to say homeopathy could have been more than placebo, because he is committed to the image of scientific medicine provided by the internal ideology of contemporary regular practice and conformed to by positivistic history of medicine.

To my mind, it is not so much the lack of 'medically valid' therapies, or the profusion of 'unscientific' ones which is significant but rather the immature character of the criteria which did exist in therapeutics, to assess their validity, effectiveness, 'success' and so on. Rothstein may offer criteria of the medical validity or otherwise of therapies but they are criteria imported from statistically and clinically sohisticated contemporary medicine and it is therefore doubtful if they really apply to nineteenth-century therapeutics.

He also argues that, in the absence of objective criteria for evaluating medical therapies, standardization of medically invalid therapies took place in order to reduce therapeutic conflicts between physicians. This enabled "professional validation of therapies

through social norms" [53] (emphasis added) to occur. Such social norms were constituted by the very asymmetries of power and ideological deviantization of the homeopaths as described throughout this work.

His evaluation of Hahnemann and homeopathy falls short of his explicit methodological framework, just because of that very framework's presuppositions. He actually imports concepts of 'demonstrability' and 'consistency' in evaluating medically valid, or invalid, therapies which are anachronistically derived from sophisticated clinical and statistical research tools of contemporary medicine. The technical basis and use of statistics in nineteenth-century medicine generally and therapeutics in particular, bears little resemblance to modern technical sophistication with such a tool of analysis.[54]

What Rothstein does is naïvely import contemporary criteria of what constitutes 'scientific medicine', and evaluate regular and homeopathic medicine according to that and their ability to respond to the market's demand for 'medically valid' therapies. This implies that 'medically invalid' therapies were eliminated for the same reasons as 'valid' ones were taken up i.e. the economic consequences of patient demands. This ignores completely the extra-economic, social and ideological processes, strategies and tactics employed by both regulars and homeopaths to convince the 'medical

market place' that their therapies were better than those of their opponents.

7.9 Conclusion: Realities and Myths

The questions, which this representative selection of medical historians totally avoid are those such as, 'Why, if regular medicine was so bad for so much of the nineteenth century, did its practitioners continue to defend its practices - including bleeding and purging - right into the 1860's and beyond? And during the Clinical-Hospital phase of therapeutic scepticism and nihilism, why did the practitioners of clinical medicine continue to regard their profession as the true source of 'scientific' and effective therapeutics when (a) it was characterised by an absence of therapy and (b) Homeopathy still seemed to be more effective than therapeutic scepticism?

Our chosen historians seem more interested in continuing to perpetuate the myth that modern medicine is the unambiguous descendent of a 'scientifically' based progressive profession steadily gathering a linear accumulation of positive therapies. Of course, it may have had to suffer conflict from various sectarian medical aberrations like homeopathy, which arose from time to time, but they were eventually virtually eliminated or marginalised by the inevitable cumulative

advances of 'scientific' medicine.

We have now reached the point where this persistently produced myth of the linear and cumulative development of modern medicine can be thoroughly rejected. This also means that the historically produced and reproduced 'legitimacy' claims for modern medicine by its practitioners and by past and present generations of medical historians, which have been erected upon this model of the development of science, are now under serious and radical doubt. The limits, paradoxes and historical nature of science and its findings have to be admitted.(55)

The cumulative, linear, progressive model of the development of medicine is functional to the myth that contemporary medicine and its occupational ancestors are the fountainhead of all that is Good and True in medicine as a science and as a healing art. Based upon this self-evaluation the so-called 'regulars' stigmatized all those who constituted a threat to their continued plausibility and ontological security, as unprofessional, unscientific, charlatans, quacks and other terms of intolerance and insult. They had the quantity, duration of institutions and political advantages necessary to be able to wage a protracted campaign against unlicensed and unorthodox practitioners. In the process they eventually monopolised the increasing

desired legitimacy of Science, the new source of truth, progress, goodness and 'sacred' authority.

In relation to this image of science the historians of (regular) medicine have spent their time in its empirical ratification. They have ignored the ideologically constitutive nature of 'scientific medicine' as a concept and phenomena abstracted from the historical data. It is in conformity to the positive heuristic of the research programme of positivistic history of medicine. They have ignored the fact that the conception and phenomenon of 'scientific medicine' was accomplished by the monopolising-marginalising processes and ideological activities of a specific collectivity of practitioners, exercising their authoritative and allocative resources in the ways already described.

The self designation of these practitioners as 'regular', 'orthodox', 'scientific' and 'professional' medicine has now been opened up to investigation and critique. Out of this painful process a more sociologically self-aware historiography of medicine can develop.

CONCLUSION

We have now considered certain problems and their solution in relation to the development of specific relationships between professional homeopaths and 'regular' practitioners. The historically and ideologically constituted character of terms such as 'orthodox' and 'unorthodox', 'regular' and 'irregular' (and their synonyms) has been exhibited. This character has been located within the context of the processes and outcomes of monopolisation and marginalisation. These processes are conceived as being reciprocally inter-related within the asymmetries of the medico-political system of occupational power.

In the research process, I have touched upon three important matters in considerations about conversion phenomena. First, that conversion is a costly, existentially painful process. Second, that it is not as arbitrary as so much sociological and philosophical theorising has assumed. Third, that the phenomenon of conversion and its maintenance is not only amenable to a reasoned explanation by the theorist but equally by the convert as he presents himself as typically convertible. The conversion texts studied contrast strongly with the explanation of conversion to homeopathy given by the regulars in their frequently hyper-critical, vituperative and misinformed attacks upon the homeopaths.

When even the 'classic refutations' by truly distinguished medical men (as Oliver Wendell Holmes) are accepted forever afterwards as determinative of the regular profession's stance towards homeopathy, in spite of their determined ignorance of the reasoned claims for homeopathy as a treatment, we are led to ask serious questions about the occupational and ideological system which sought to defend itself by the means I have described.

We see a profession in turmoil experiencing successive crises of faith, as one medical system after another was introduced, and threatened more than it would admit by the homeopathic 'heresy'. It was not simply the case of a monopolistic 'medical mafia' trying to eliminate a rival 'gang'. It was a condition of severe existential crisis which evoked all sorts of self-defensive reactions designed to maintain its continuity in the face of a deep threat to its social and cognitive plausibility structures.

The later nineteenth century was a crucial period for the accomplishment of the contemporary 'facticity' and 'triumph' of 'modern scientific medicine'. This 'triumph' has been much celebrated in the standard, cumulative, linear, progressivist history of medicine. Consequently, this received historiography has continued the ideological delegitimation of Hahnemann and homeopathy. Even when it has been conceded that homeopathy was shunned for less than the 'scentific' reasons given by the regular

ideologues at the time, the conclusions which should have followed from such an admission have not been forthcoming. Those conclusions can now be clearly stated.

First, that for most of the century, homeopathy could not reasonably be perceived as drastically inferior as a therapeutic system, compared to either heroic, nihilistic, neo-vigorous, eclectic, or even sceptical therapeutics. The regulars just could not afford to concede that to the public, to the homeopaths and especially not to themselves. This is why they could stoop to corrupting official statistics by suppressing the homeopathic returns from the British government cholera report in 1855.

Second, such a non-condemnatory judgement has been suppressed because of the anti-homeopathic (anti-quack) ideology constructed by the ideologues of the regular profession, which reduced homeopathy to being equal to, or worse than, no treatment at all. This ideology also functions as an assumption in the standard history of medicine.

Even though the new 'debunking' social history of medicine may be more sceptical of the contemporary profession's past ideological claims, as well as the positivist assumptions of the standard history of medicine, it still tends to operate, epistemologically and methodologically, within the science/ideology polarity; or if not that, then it operates

within the sectional interests/ideology polarity as a means of criticising the domination aspects of regular medicine. In the latter case 'interests' (often undefined) function as a dynamic link between the 'dirty' political/ideological factors of the institutions of science and the 'purity' of the internal, epistemologically 'true' conceptual aspects of science.

My position is not to be confounded with the Durkheimian thesis that a stigmatized enemy is 'created' in the interests of group solidarity. All the evidence shows that homeopathy was a professional as well as an existential threat. There are no historical records to show that there was any conspiracy to 'manufacture' a homeopathic threat; neither are there records of denials of the existence of a professional threat from homeopaths.

My purpose has <u>not</u> been to set the historical record straight by canonising Hahnemann as having <u>really</u> been one of the unrecognized 'saints' of medical history. Nor has it been an attempt to place homeopathy on the 'proper' side of the science/pseudo-science divide. Rather it has been an attempt to show that such dichotomies and evaluations are no longer adequate to the task of explaining the rejection of homeopathy throughout the nineteenth century, and to go beyond them in a concrete way.

Throughout, there have been severe problems in separating

the ideological from the practical issues in medical debates. This calls for even more careful exercise of the historian's craft, involving sensitivity to the limitations of supposedly 'scientific' primary sources, and an awareness of the problems of the interrogation of prejudiced secondary sources. On the basis of the reliable historical study of what actually happened (at the level of the debates), we might proceed to a history of the consciousness of the whole problem of medical marginalization, in which our secondary sources become primaries along with the others.

On the basis of this research I have formulated an informal descriptive theory of marginalization which significantly advances previous theoretical and empirical work on marginality. I conceive of marginality as an historically and therefore socially produced and reproduced phenomenon. This is accomplished within the structured asymmetries of power and human agency. Such an understanding of the contingent and structured achievement of the domination of the division of medical labour by a hierarchical regular profession, provides a far more adequate explanation of the historical trajectories of it and homeopathy.

Since the normative boundaries between 'science' and so-called 'pseudo-science' are no longer tenable, it follows that neither are the analogous academic boundaries between the history and sociology of 'scientific' medicine, and the history and sociology of 'deviant' medicine. (It seems

to me that even the normative division between history and sociology is methodologically suspect too). A more sociologically aware penetration of such anachronistic polarities as 'orthodox'/'unorthodox' medicine, together with a more acute historical craftsmanship by sociologists of medicine would properly relocate the history and sociology of medical 'heresy' and marginality at the centre of future scholarly considerations on such matters.

The theoretical and methodological problems involved in such an undertaking are great but not insuperable. My own approach has been to maintain a continual reciprocal movement between the investigation of historical events and their contingencies, and the equally necessary theoretical, sociological reflection upon the processes and structured-ness of individual and collective human agency. This has prevented my theoretical intentions from becoming the sociological pretensions of ahistorical 'Grand Theory' and kept it much closer to the need for an historical sociology of process.

APPENDIX 1.

Diagram 1. Medical Cosmologies 1770-1870

[Source. N.D. Jewson (1976) op.cit. p. 228. Note: His chronology needs extending from 1770 to at least 1892 when Behring's diphtheria anti-toxin was used on large scale and the Bacteriological-Laboratory Cosmology was well established].

	(c.1770-1840) Heroic-Bedside Medicine	(c.1830-1880) Clinical-Hospital Medicine	(c.1860-1910) Bacteriological-Laboratory Medicine
Subject matter of Nosology	Total symptom complex	Internal organic events	Cellular function
Focus of Pathology	Systemic-dyacrasis	Local lesion	Physico-chemical process
Research Methods	Speculation & Inference	Statistically orientated clinical observation	Laboratory experiment according to scientific methods
Diagnostic Technique	Qualitative judgement	Physical examination before & after death	Microscopic examination and chemical tests
Therapy	Heroic & extensive	Sceptical (except surgery)	Sceptical eclecticism and a few specifics based on aetiological knowledge of bacteria
Mind/Body Relationship	Integrated: psyche & soma seen as part of same system of pathology	Differentiated: psychiatry a specialized area of clinical studies	Differentiated: psychology a separate scientific discipline

Diagram 2. Three Modes of Production of Medical Knowledge

[Source. N.D. Jewson (1976) p.228].

	Patron	Occupational role of medical investigator	Source of patronage	Perception of sick person	Occupational task of medical investigator	Conceptual-ization of illness
Heroic-Bedside Medicine	Patient	Practitioner	Private fees	Person	Prognosis & therapy	Total psycho-somatic disturbance
Clinical-Hospital Medicine	State; or Hospital	Clinician	Professional career-structure	Case	Diagnosis & classification	Organic lesion
Bacteriological -Laboratory Medicine	State; Hospital & academy	Scientist	Scientific career-structure	Cell-complex	Analysis & explanation	Biochemical process

Diagram 3. Cosmologies and major types of occupational control 1770-1900

Source N.D. Jewson (1976) and T. Johnson (1972)

	Heroic-Bedside Medicine	Clinical-Hospital Medicine	Bacteriological-Laboratory Medicine
Correlated societal formation	Guild Capitalism	Entrepreneurial Capitalism	Colonial-State Capitalism
Dominant Occupational control system	Client patronage (consumer defines needs)	Collegiate (producer defines needs of consumer)	Mediative. State mediates producer-consumer relations
Main Intellectual trends	Speculative Idealism	Mechanistic & organismic materialism	Physico-chemical reductionism
General medical philosophies	Medical Transcendentalism and Idealism	Medical materialism	Medical reductionism
Types of medical explanation	Vitalism	Mechanism and Organicism	Micro-biological mechanism

Diagram 4. The Phases of the Paris School of Clinical Medicine 1794-1848

Source: Constructed from Ackerknecht (1967)

	1794-1816	1816-1830	1830-1848
Subject matter of Nosology	Internal organic	Internal organic	Internal organic
Focus of Pathology	Local lesion - based upon anatomical study	Local lesion - based upon physiology & symptomology	Local lesion - based upon patho-physiology
Research Methods	Post-mortem Clinical observation (a mathematical-statistical orientation)	Clinical observation (a more speculative orientation)	Clinical observation (a statistical orientation)
Diagnostic Technique	Physical examination	Physical examination	Physical examination
Therapeutics	Sceptical (expectant)	Active intervention (anti-phlogistic)	Eclectic mix of active & expectant therapies relative to diagnosis, patient constitution & known action of therapies
Dominant teacher (s) clinician(s)	Pinel & Bichat	Broussais	Chomel, Louis, Andral, Trousseau

APPENDIX 2

For example, reports in the Brit. Jour. Hom. Vol.1 (1) 1843 p.57-68; on cholera epidemics in Russia, Italy and France reported the following figures. No details of modes of treatment are given, only overall comparison with allopathic treatment.

Table 1.(op.cit.p.58)

(p.58) Cholera patients treated at Tischnowitz from 7th. Nov. 1831 - 5th. Feb. 1832

	Patients	Cured	Died	% mortality
Treated Allopathically	331	229	162	30.82
Treated Homoeopathically	278	251	27	9.71
Treated with camphor (no physician)	71	60	11	15.49
Inhabitants - 6671 Totals	680	540	140	20.58
				(Avg. = 18.67%)

(% mortality column is my own calculation)

Table 2.(op.cit. p.58)

(p.58) Cholera patients treated at Wishney Wololschok (Russia) by Dr. Seider

	Patients	Cured	Died	% mortality
Treated Allopathically	93	24	69	74.19
Treated Homoeopathically	109	86	23	21.10
Left to nature or own caprices	49	16	33	67.34
				(Avg. = 54.21%)

(% mortality is my own calculation)

Table 3.(op.cit.p.59)

Results of treatment of cholera patients in Vienna

	Patients	Cured	Died	% of deaths
Allopathic treatment	4500	3140	1360	31
Homoeopathic treatment	581	532	49	8

Table 4.(op.cit.p.59)

Results of treatment of cholera patients at Bordeaux

	Patients	Cured	Died	% of deaths
Allopathic treatment	104	32	77	69 (74% mortality)
Homoeopathic treatment	31	25	6	19

Table 5. (Source Brit. Jour. Hom. 3 (10) p.101-105 by Dr.A.E.Hamilton).

Comparative results of the homoeopathic and allopathic treatment of Asiatic Cholera (op.cit.p.103)

Mortality for allopathic treatment	-	63%
Mortality for homoeopathic treatment	-	11%

REFERENCES TO CHAPTER 1

1. T. J. Johnson (1972) 'Professions and Power', MacMillan Press Ltd. See this for an excellent review of the trait, natural history and functionalist approaches to the professions (ch. 1-2), followed by consideration of power through a typology of occupational control systems (ch. 3-7). Indeed, Johnson argues that a profession is not, then, an occupation, but 'a means of controlling an occupation' (p. 45). He analyses this thesis by explicating different types of occupational control expressed in varying sources of professional legitimation, domination, kinds of producer-consumer relationship, nature of the consumer, sources of occupational recruitment, colleague relationships, ideology and the state of medical knowledge.

2. A. Giddens (1973) 'The Class Structure of the Advanced Societies', Hutchinson University Library, ch. 6-10 and ch. 14. Although he advances class theory considerably he tends to collapse professionals into middle-class white collar workers and neglects the implications of 'professionalization' as a 'collective' social mobility project for class theory. A point which Parry and Parry (1976) develop.

3. a M. S. Larson (1977) 'The Rise of Professionalization: a sociological analysis', University of California Press.
   b N. Parry and J. Parry (1976) 'The rise of the medical profession: a study of collective social mobility', Croom Helm, London.
Larson and the Parrys describe 'professionalization' as a collective, upward social mobility project of certain sections of the rising bourgeoisie (e.g. tradesmen, former craft-guilds and technical industrial workers). Larson deals with medicine, law and engineering whilst the Parrys deal only with medicine. Although Larson makes no reference to the Parrys' work it seems to me that it does all that the Parrys' work does and more, in that the place of scientific knowledge, process of 'cognitive standardization' and the relation of these to the emerging national education systems in Europe and the United States as analysed and related to the 'professionalization project' of market monopoly and upward social mobility.
Both combine the insights and analyses of Weber and Marx on class and status hierarchies in order to understand the effects of the emerging capitalist mode of production upon the division of labour, relations of power, system of domination and legitimation of the occupational boundaries of certain professions.

4. H. Perkin (1969) 'The Origins of Modern English Society 1780-1880), RKP and University of Toronto Press, pp.252-70, 272, 319-23, 325-26, 338, 428-29, 451.

5. W. J. Reader (1966) 'Professional Men: the rise of the Professional classes in nineteenth-century England', Weidenfeld and Nicolson.

6. D. H. Calhoun (1965) 'Professional Lives in America: structure and transition 1750-1850', Harvard University Press.

7. a W. G. Rothstein (1972) 'American Physicians in the nineteenth century: from Sects to Science', John Hopkins University Press.
   b D. Hamilton (1981) 'The Healers: a history of medicine in Scotland', Canongate (esp. chs. 4-6).

8. cf. Larson (1977) op. cit.

9. a H. L. Coulter (1973-75) 'Divided Legacy: a history of the schism in medical thought', 3 vols.
   Vol. I 'The Patterns Emerge: Hippocrates to Paracelsus' (1975) Wehawken BK Co.
   Vol. II 'Progress and Regress: J. B. Van Helmont to Claude Bernard' (1977) Wehawken BK Co.
   Vol. III 'Science and Ethics in American Medicine 1800-1914' 1973 McGrath Pub. Co.
   b G. H. Daniels (1967) 'The process of professionalization in American Science: the emergent period 1820-1860'
   ISIS (58) p.151-160.
   c S. J. Novak (1973) 'Professionalism and Bureaucracy. English doctors and the Victorian Public Health Administration'.
   Journal of Social History 6(4) p. 440-62.
   d W. G. Rothstein (1972) op.cit.

10. a J. C. Berlant (1975) 'Profession and Monopoly: a study of medicine in the United States and Great Britain', University of California Press.
   b D. Daman (1979) 'The creation and diffusion of a professional ideology in nineteenth century England'.
   Soc. Rev. 27(1) p. 113-38.
   c Carol L. Kronus (1976) 'The evolution of occupational power: an historical study of task boundaries between physicians and pharmacists'.
   Sociology of Work and Occupations 3(1) Feb. p.3-37.
   d M. S. Larson (1977) op.cit.
   e N. Parry and J. Parry (1976) op.cit.
   f J. Sadler (1978) 'Ideologies of 'Art' and 'Science' in Medicine: the transition from medical care to the application of technique in the British medical profession', in Krohn, Layton and Weingart (eds) (1978) 'The Dynamics of Science of Technology' Reidel p.177-215.
   g I. Waddington (1975) 'The development of medical ethics - a sociological analysis'.
   Med. Hist. 19 p.36-51.

11. A. Giddens (1979) 'Central Problems in Social Theory: action, structure and contradiction in social analysis', MacMillan Press Ltd. p.8. Also see ch. 7esp. pp.230-33.

12. In Britain, prior to the 1858 Medical Act, 'professional homeopaths' were those homeopaths whose educational qualifications to practice medicine would derive from recognised non-homeopathic institutions. After 1858 they are those homeopaths

who have been qualified as practitioners at a regular training institution, been licensed by it, then placed on the GMC Register as 'registered practitioners' but who also practice homeopathically qua therapeutics.

13. I use the term 'fate' in an ironic sense, not in the sense of an absolutely casually pre-determined end state. Yet in the face of deeply embedded medical institutions and ideology already in existence I cannot help having some sympathy for the concept of the fatedness of homeopathy in Britain. In the New World with its lack of institutions of comparatively long duration, homeopathy achieved greater prominence in the public's mind.

14. P. M. Strong (1979) 'Sociological Imperialism and the Profession of Medicine: a critical examination of the thesis of medical imperialism'.
Social Science and Medicine 13A(2) p.144-215.
Strong argues that this thesis about medicine can be turned back upon sociology to show the appeal of conservatism and radicalism in its analysis of the profession of medicine, during its own trajectory of occupational development.

15. Op.cit. p.199.

16. a Ivan Illich (1977) 'Limits to Medicine. Medical Nemesis: the expropriation of health', Penguin Books 1977.
Central to his position is the notion of the 'medicalization of life'. That is the extension of medical concepts and practices into more areas of ordinary life.
For the basics of this see Illich (1977) ch. 2 p.47-132. Also the summary in (a) Ivan Illich (1975) 'The Medicalization of Life', Journal of Medical Ethics 1 p.73-77, and in the same volume; (b) Illich 'Clinical damage, medical monopoly, the expropriation of health: Three dimensions of iatrogenic tort'. Journal of Medical Ethics 1 p.78-80.
(c) Renee C. Fox (1977) 'The Medicalization and Demedicalization of American Society' Daedalus 106(1) p.9-33 for some critical comments on Illich's thesis.

17. a Daedalus 106(1) 1977 for a special issue on Medicine, Monopoly and Medicalization.
b E. Freidson (1970) 'Profession of Medicine: a study of the Sociology of applied knowledge', Harper & Row, Pub. Inc.
c E. Freidson (1970) 'Professional Dominance: the social structure of medical care', Aldine Pub. Co.
d Ian Kennedy (1980) Reith Lectures: 'Unmasking Medicine', cf. 'The Listener' 6 Nov.-11 Dec. 1980.
e E. Rayack (1967) 'Professional Power and American Medicine: the economics of the American Medical Association', World Pub. Co. (See especially ch. 6).

18. a Barbara and John Ehrenreich (eds) (1971) 'The American Health Empire: power, profits and politics', Vintage Books. (Report of the Health Policy Advisory Centre).
    b B. Ehrenreich (1975) 'The health care industry: a theory of industrial medicine'.
    Social Policy 6(3) Nov./Dec. p.4-11.
    c B. Ehrenreich and Deidre English (1979) 'For her own good: 150 years of the experts' advice to women', Pluto Press, for a feminist critique of western capitalist medicine using a crude version of Marxism.
    d J. Ehrenreich (ed) (1978) 'The cultural crisis of modern medicine'. Monthly Review Press (especially p.1-79).
    e Vicente Navarro (1976) 'Medicine under Capitalism', Croom Helm, London.
    f V. Navarro (1977) 'Political Power, the State and their implications in medicine'.
    Rev. Rad. Pol. Econ. 9(1) p.61-81.
    g V. Navarro (1978) 'Class Struggle, the State and Medicine: an historical and contemporary analysis of the Medical Care sector in Great Britain'. Martin Robertson.
    h V. Navarro (1978) 'The crisis of the western system of medicine in contemporary Capitalism'.
    Int. Journal Health Services 8(2) p.179-211.
    i L. Rodberg and G. Stevenson (1977) 'The Health Care Industry of Advanced Capitalism'.
    Rev. Radical Polit. Econ. 9(1) p.104-15.
    j J. W. Salmon (1977) 'Monopoly Capital and the reorganization of the health sector'.
    Rev. Radical Polit. Econ. 9(1) p. 125-33.
    k H. B. Waitzkin and B. Waterman (1974) 'The exploitation of illness in Capitalist Society'. Bobbs-Merrill Co. Inc., N.Y.

19. It is strange how Advanced Capitalism is so frequently identified with 'American' Capitalism which in reality is atypical when considered in comparative and historical perspective.

20. Robert W. Friedricks (1970) 'A Sociology of Sociology'. Free Press and Collier-MacMillan.
cf. ch. 3 'Sociology: The Prophetic Mode', p. 57-75 and ch. 6 'Recovery of the Prophetic Mode', p.111-34.

21. P. M. Strong (1979) op.cit. p.205.

22. idem.

23. idem.

24. For example, the movement for 'natural' childbirth is, argues Strong, securely based upon the advances made in modern medicine. This has removed the dangers of 'non-medicalized' childbirth that existed prior to anaesthesia and asepsis in western societies. These dangers still exist in some contemporary

'primitive' cultures beloved by the classical anthropologist.

25. This position and its criticism are equally based upon the analysis of social systems in terms of statics (synchrony) and dynamics (diochrony). In social statics a social system was analysed in terms of social structures and hence all sense of time was eliminated. The Parsonian concept of 'social systems' became identified with stability, equilibrium, normative-consensus and integration. It found conceptual and empirical difficulty with the phenomena of conflict, revolution and societal breakdown. Thus a contrasting conflict sociology arose of liberal functionalist (e.g. Lewis Coser's conflict functionalism) and conservative neo-Marxist varieties (e.g. Ralph Dahrendorf's dialectic conflict theory).
cf. J. H. Turner (1974) 'The Structure of Sociological Theory', Dorsey Press, for a good summary and analysis of the positions of Parsons, Coser and Dahrendorf in chs 3, 7 and 6 respectively.

26. This is based on a criticism of the McKeown thesis, in his 'The Role Medicine'(1976), ''that high-technology medicine has contributed far less than might be imagined to advances in our health'' (Strong (1979) op.cit. p.206) and that it was improved housing, sanitation, sewage disposal and nutrition that made the most marked improvements in the general health of the population. The critics of McKeown cited are open to equal criticism themselves in applying contemporary epidemeological and sociological criteria to past statistical tables not constructed with such 'modern' criteria in mind.

27. P. M. Strong (1979) op.cit. p.206.

28. op.cit. p.207.

29. In 18th century Europe the physicians, and later the ancillary medical professions, were incorporated into quite extensive, centralized state bureaucracies well before governments in Britain and the United States began to extend their state bureaucratic administrations to the medical and welfare fields. See R. Shryock (1948) 'The Development of Modern Medicine'. Victor Gollanz.

30. P. M. Strong (1979) op.cit. p.209.

31. op.cit. p.210. Also see, as examples of this professional practitioner dominance over the medical division of labour, the historical sociology of Carol L. Kronus (1976) op.cit., G. V. Larkin (1978) 'Medical Dominance and Control: Radiographers in the division of labour'.
Soc. Rev. 26(4) p.843-58, and G. V. Larkin (1983) 'Occupational Monopoly and Modern Medicine'. Tavistock Pubs. Ltd.

32. Brian Inglis (1965) 'The Case for Unorthodox Medicine'.
G. P. Putnam's Sons.

Robert Eagle (1978) 'Alternative medicine: a guide to the medical underground'. Futura Pubs. Ltd.

33. cf. M. S. Larson (1977) op.cit.; Parry and Parry (1976) op.cit.

34. As with the traditional status of the physicians, especially the members and licenciates of the Royal Colleges of Physicians.

35. As with the apothecaries through the 1815 Apothecaries Act and later the apothecary surgeons with the 1858 Medical Act in Great Britain. In the USA the status of regular practitioners was improved by reform of medical education rather than by legislation.

36. J. W. N. Watkins Methodological Individualism Part 3, in J. O'Neill (ed) (1973) 'Modes of Individualism and Collectivism' Heinemann, p.143-84.

37. E. Durkheim (1964) 'The Rules of Sociological Method'. Free Press, esp. chs. 1 and 5, and T. Parsons (1951) 'The Social System' RKP, ch. 1.

38. Alan Dawe (1970) 'The Two Sociologies'. B.J.S. 21, p.207-18; also in K. Thompson and J. Tunstall (eds) (1971) 'Sociological Perspectives'. Penguin Education and Open University Press, p. 542-54, A. Giddens (1979) op.cit. ch. 1 and 2.

39. a A. Giddens (1976) 'New Rules of Sociological Method: a positive critique of Interpretive Sociologies'. Hutchinson, esp. chs. 2, 3 and Conclusion.
b A. Giddens (1979) 'Central Problems of Social Theory: action, structure and contradiction in Social Analysis'. MacMillan Press Ltd.

40. Giddens (1979) op.cit. ch. 2.

41. Giddens (1976) op.cit. ch. 3, esp. p.116-18, and Giddens (1979) op.cit. ch. 5, esp. p.188-90.

42. Giddens (1979) ibid. p.189.

43. This is evident in the work of the structural-functional tradition in general but in that of the Parsonian school in particular. See Talcott Parsons (1951) 'The Social System'. Free Press, esp. pp.26-36, 177-80.
Talcott Parsons (1961) 'Societies: evolutionary and comparative perspectives'. Prentice-Hall. N.J.
Talcott Parsons (1971) 'The System of Modern Societies'. Prentice Hall, Inc. N.J.
For an excellent summary and critical view of Parsonian functionalisms see J. H. Turner (1976) 'The Structure of Sociological Theory'. Dorsey Press, ch. 3 p.28-59.

44. Giddens (1979) op.cit. p.189. My emphasis.

45. Op.cit. he says ''To analyse the ideological aspects of symbolic orders . . . .is to examine how structures of signification are mobilised to legitimate the sectional interests of hegemonic groups'', (p.188).

46. M. S. Larson (1977) op.cit. p.5.

47. idem . . .footnote:*

48. Giddens (1979) op. cit. p.55.

49. ibid. pp.41-42, 53-59, 210-16.

50. The social roles available for regular medical practitioners in the U.S. and Great Britain during the 19th century of course developed, changed and disappeared at varying rates. However we may legitimately argue that prior to the 1815 Apothecaries Act in Great Britain the available regular medical roles were those of 'physician', 'apothecary' and 'surgeon'. In the early U.S. such rigid distinctions, due to the lack of a dominant natural, medical elite, were relatively absent and medical roles were more fluid. The 1858 Medical Act in Britain 'officially' legitimated the 'G.P.' role whilst hospital-based official medicine legitimated the role of physician/consultant. Increasing medical knowledge produced increased specialism and so increased the roles available in the medical career structure.

51. 'Neutralization' and 'stigmatization' are two ways of denying social legitimacy to irregular medical practitioners. Legitimation-denial also renders such practitioners marginal to 'mainstream' medicine. This strategy has also been historically employed to subordinate medical specialisms, within mainstream medicine, to the dominant professional practitioners and their institutions (cf. G. V. Larkin (1978) and (1983) op.cit.). These and other social control strategies will be dealt with substantially in ch. 6.

52. Giddens (1979) op. cit. p.189.

53. The term 'regular practitioner(s)' denotes the following phenomena:-
(a) the production and reproduction of a set of medical practitioners accepted as legitimate by members of the wider society;
(b) the dominance of these medical estates, elites and sectional interests which claim (and are accorded) 'legitimate' authority, status and power compared to irregular practitioners.
(NB. These irregulars, especially the 'learned professional' ones, like the Homeopaths, posed a specific threat to the plausibility of the claims of regular medical knowledge and practice.)

(c) those practitioners who held to definite bodies of medical knowledge, and practices (including tools and techniques), which they regarded as constituting the legitimate science and art of medicine;
(d) those practitioners who have gained relevant and specific legal privileges from the political community to be employed in the control of its members and against those who deviate from received knowledge and practice in any radical way.

54. Certain distinctions are made about medical therapy as follows:
(i) 'Heroic Interventionist Therapeutics' - actual intervention by the physician in the biochemical, psycho-somatic and physiological pathologies of the human organism. This can be in terms of chemical, psychological and mechanical intervention strategies. Applied to the heroic-bedside medicine, dominant during the first four decades of the 19th century, this was mainly massive chemical and mechanical intervention to make an impression upon the total symptomology of the sick person. The feature common to heroic and homeopathic medicine was the belief that giving the patient a remedy or drug was the primary way of curing illness or improving their health. This can be easily recognised when compared to a practice like naturopathy which does not 'give' the patient any pills, potions or potencies, but requires a radical change in diet or lifestyle.
(ii) 'Expectant therapy' this was prominent during the clinical-hospital phase of the development of regular medicine. It was founded on the therapeutic scepticism of previous heroic medicine. The central principle was that good, safe healing was effected by the natural recuperative powers of the sick person. This was summed up in terms of the 'vis medicatrix naturae' and the concept of self-limited diseases. Thus the physician was not to interfere in the natural processes of the sick person as these processes were restoring that patient to health. The doctor could only make the patient as comfortable as possible, provide quiet, fresh air, sunlight, sensible diet and emotional support. Its analogue in surgery was that of conservatory surgery.
(iii) 'Eclectic therapeutics' Midway between the positions of massive chemical and mechanical intervention, as in Heroic-Bedside medicine, and the non-intervention of medical nihilists, within certain aspects of Clinical-Hospital medicine, lay the practice and philosophy of those like Worthington Hooker. This was termed 'Rational Therapeutics' (cf. his book of that title, 1858). It was the 'judicious' application of appropriate remedies - including bleeding - whether they be from the schools of heroic intervention or from those of therapeutic scepticism/nihilism. He sought to correct the 'prevailing disposition to exalt negative means of cure, above those which are positive' (p.3). He proposed a discriminating medical practice which sought the remedy appropriate to each case and was non-dogmatic in relation to heroic and nihilistic therapeutic schools. Hooker's position fits in with a broader

one of 'liberal eclecticism' (p.50). This was based upon general principles of practice and the avoidance of any 'exclusive' treatments. It involved the cultivation, by the physician, of the knowledge of various remedies, the contingencies of individual constitutions and environments, and decisions as to therapy, carefully considering all these relevant elements.
(iv) 'Preventive therapy or prophylaxis': this lies somewhere between interventionist and non-interventionist positions. It is interventionist in that it actively seeks to intervene in the immediate 'environment' of the patient and to either remove the patient from the hostile environment to one which can be largely controlled/modified by the doctor, or control/modify the patient's environment to reduce the threat of illness occurring or intensifying.
It is non-interventionist in the sense that it is mainly drugless therapy. It doesn't give the patient anything to take to cure/palliate the illness. It simply seeks to create the optimum environmental conditions for health and recovery from illness.
('Author's note': It is interesting to imagine the effects on medical style, theory and research, if the preventive mode of medicine became dominant, rather than that of biochemical and high-technology positive intervention as at present. It would radically transform the approach to cardio-vascular disease and cancer for example, yet its social-environmental approach would 'medicalize' even greater areas of human life.

55. This general point is repeated by a number of recent histories of 19th century medicine in G.B. or the U.S.A.
W. G. Rothstein (1973) pp.10, 18-19, 23, 41-42, 61, 64, 84, 185 and ch. 14.
Martin Kaufman (1976) 'American Medical Education: the formative years, 1765-1910', Greenwood Press pp. 72, 121, 143.
But the details of this claim will be made in ch.3 sections 3.6 to 3.8.

56. Frederick Jackson Turner (1935) 'The United States 1830-1850: the nation and its sections'. W. W. Norton and Co. Inc. ch. 2 for the general political scene.
W. G. Rothstein (1972) op.cit. ch. 4-7 and J. F. Kett (1968) 'The formation of the American Medical Professions'. Yale Univ. Press, ch. 1 for its effects on medical licensing.

57. M. Kaufman (1976) op.cit. ch. 9.

58. Op.cit. p.143.

59. Op.cit. p.149.

60. 'Flexnerization': i.e. reform of medical education according to the proposals as set out in the Flexner Report of 1910.

61. Martin Kaufman (1971) 'Homeopathy in America: the rise and fall of a medical heresy'. Johns Hopkins Press.
Although an excellent historiography of the rise and fall Homeopathy in America, its conclusions read like a cautionary tale from an Aesop's fable. For a more extended critique of his work see final chapter.

62. B. J. McCormick, P. D. Kitchen et.al. (1974) 'Introducing Economics'. Penguin Books, cf. ch. 17 and 18 for a simple presentation of these ideal types.

63. Max Weber (1949) 'The methodology of the Social Sciences'. Free Press (translated and edited by E. A. Shils and H. A. Finch) p.90.

64. J. C. Berlant (1975) op.cit. p.50-51.

65. M. S. Larson (1977) op.cit. p. 38.

66. Op. cit. p.14.

67. a P. L. Berger and T. Luckmann (1967) 'The Social Construction of Reality: a treatise in the Sociology of Knowledge'. Penguin Books.
cf. p.110-146 for a consideration, at an abstract level, of the 'objective' social aspects of symbolic universes together with their conceptual and institutional maintenance. The internalization, maintenance and transformation of the 'subjective' corollary of those 'objective' aspects, is discussed on pp.149-204.

b Harold Perkin (1969) op.cit. for a social historian's view of this change.

c Karl Polanyi (1957) 'The Great Transformation: the political and economic origins of our times'. Beacon Press.
Perkin and Polanyi provide the social, political and economic elements and processes which constituted the radical shift from one historical socio-economic formation to another. From 'feudalism' to 'modern industrial capitalism', in Max Weber's terms (cf. H. H. Gerth and C. Wright Mills (1948) 'From Max Weber'. RKP p.66-67), or, from 'feudalism' to 'modern bourgeois capitalism' as Marx would have it (cf. K. Marx (1963) 'Selected Writings in Sociology and Social Philosophy'. Penguin Books. Edited by T. B. Bottomore and M. Rubel. Translated by T. B. Bottomore, p.137-54).
Of course there were many and varied continuities between these historical social formations and intermediary formations but a radical break was made under the impact of the Industrial Revolution. This was marked not so much by human greed and callous capitalists - present as they were - but by ''the social devastation of an uncontrolled 'system', the market economy'' (R. M. MacIver in Foreword to Polanyi (1957) ibid. p.x).

68. A point explicitly recognized by many historians of medicine. For example:-
    a W. S. Larson (1977) op.cit.
    b W. G. Rothstein (1972) op.cit. ch. 1, 3, 7, 8, 11 and 12.
    c R. H. Shryock (1948) op.cit. ch. 13.

69. a W. G. Rothstein (1972) op.cit. ch. 7, 8, 11, 12 for Thomsonians, Eclectics and Homeopaths.
    b Dr. Symonds 'Some truths in medicine that may be allied to heresies'. Lancet (1842-43) vol. 1. Sat. Nov. 12 1842 p.244-45 where he writes upon homeopathy and hydropathy.
    c Dr. R. M. Glover, Lecture VI, 'Lectures on the philosophy of medicine'. Lancet vol. 1 1851 Jan. 11 p.35-38 on Quackery and psuedo-science. Included in the lecture are phrenology, mesmerism, hydropathy, teetotalism, vegetarianism and homeopathy.
    d A letter from Dr. T. Turner opposing homeopathy and hydropathy, in 'The Lancet' vol. 2 1851 Sat. Aug. 30 p.215-16.

70. This is standard psychological knowledge and we will be making use of it, along with other approaches, but particularly in chapter 6.
I only indicate at this point the work of Leon Festinger (1957) 'A Theory of Cognitive Dissonance'. Stanford Univ. Press. A layman's summary is in Festinger (1962) 'Cognitive Dissonance'. Sci. Am. 207(4) Oct. p.93-99. For an anthropologist's analysis of the concepts of social evil, 'pollution' and 'taboo' see Mary Douglas (1966) 'Purity and Danger'. RKP esp. ch. 1-2, 6-8. However, it cannot be applied to this thesis outright, otherwise it simply produces a gloss upon the configurations of politics, power and people involved in the twin processes of monopolisation and marginalization.

71. Berlant (1975) op.cit. p.53.

72. Op.cit. p.54-55.

73. Thomas Percival wrote his 'Medical Ethics' in 1794 and published it in 1804. He undertook it in 1791 on the request to write up a scheme for professional conduct following a dispute amongst House staff at the Manchester Infirmary in 1789.
Conventional functionalist and 'evolutionary' sociological analysis has argued that the development of professional ethics received its impetus from practitioner-client relationship problems and the necessity to distinguish themselves from the unqualified practitioners. This would enable the public to distinguish who was a competent or incompetent, honourable or dishonourable practitioner. However, recent work has located the raison d'etre of the development of medical ethics more in the necessity to reduce intra-professional conflict. Berlant (1975) op.cit. and Ivan Waddington (1975) 'The development of medical ethics - a sociological analysis'. Med. Hist. 19 p.36-51.

74. N. Parry and J. Parry (1976) op.cit. p.85.

75. Op.cit. p.86 argues this point, which is restricted to the European and Anglo-American class based societies.

76. idem . . . quoting F. Parkin 'Strategies of Social Closure in Class Formations', p.3, in F. Parkin (ed) (1974) 'The Social Analysis of Class Structure'. Tavistock p.1-18.

77. Parry and Parry (1976) op.cit. p.86-87.

78. F. Parkin 'Strategies of Social Closure in Class Formation' in F. Parkin (ed 1974) op.cit.
Note: Solidarism may be based in either traditional communalism, or in instrumental calculation of strategic advantages resulting from specific collective activity.

79. Parry and Parry (1976) op.cit. p.87.

80. idem.

81. Berlant (1975) op.cit. p.52. My emphasis.

82. A. Giddens (1979) op.cit. p.68.
N.B. 'Practical consciousness' is tacit 'non-discursive' but not unconscious knowledge that is applied in the practice of any conduct and is involved in the production and reproduction of social institutions/systems over time, just as much as that of 'discursive consciousness' is. The latter can be brought to and held in the consciousness. It is verbalizeable and constitutes part of the distinctive human ability to account for one's own action in relation to oneself and others. It is a distinctive feature of the everyday reflexive monitoring of actions that human agents routinely engage in when asked to justify or account for their actions. See A. Giddens ibid. p.56-59 on the stratification model of action.

83. Berlant (1975) op.cit. p.56.

84. Berlant (1975) op.cit. p.55.

85. E.g. Discussion of the disciplining of a Mr. Robinson for advertising the City Homeopathic Dispensary (at 20, Moorgate Bank, London) in Lloyds Weekly London newspaper on March 26, June 18, Oct. 29, Nov. 19 and Dec. 3, 1865. Robinson was forced to resign from BHS membership by Feb. 4, 1866.
cf. British Homeopathic Society Minutes and Correspondence, Vol. 5 (Oct. 8, 1863 - June 26, 1879) meeting on Dec. 7, 1865.

86. Berlant (1975) op.cit. p.55.

87. Berlant op.cit. p.54.

88. idem.

89. M. Schudson (1980) 'Review Article'. Theory and Society 9(1) p.215-29. Makes the same point in a review of M. S. Larson (1977) op.cit. p.221-222 of that review.

90. M. Schudson (1980) op.cit. p.225.

91. For example – the response of a regular M.D. to some 'deviant' medical practices.
cf. Dr. R. M. Glover op.cit. (note 69(c) above).

92. I. Waddington (1979) 'Competition and Monopoly in a Profession: the campaign for medical registration in Britain'.
Amsterdam Sociologisch Tydschrift 6(e) p.289.

93. op.cit. p.307.

94. Hansard 149. 1858 col. 650.

95. J. L. Berlant (1975) op.cit. p.53.

96. For a general indication of this see:-
I. Waddington (1979) op.cit. p.313-16 for Britain, and
G. E. Markowitz and D. L. Rosner (1973) 'Doctors in Crisis: a study of the use of medical education to establish modern professional elitism in medicine'.
American Quarterly 25 p.83-107, for the situation in the USA.

97. I Waddington (1979) op.cit. p.289.

98. Op.cit. p.290.

99. The BMA had originally been a very radical GP association. Indeed it had access to the pages of the 'Lancet' via one of its 23 council members, Thomas Wakely, the Lancet radical editor. The BMA met with the Provincial Medical and Surgical Association (PMSA) in 1841 and the PMSA took over its title (1856) but expanded its own scope as a moderate medical reform organisation. The PMSA had itself been founded in 1832 through the efforts of Charles Hastings, its first secretary, from his base of operations at the Worcester Infirmary.

a E. M. Little, FRCS (ed) (1932) 'History of the BMA 1832-1932'. BMA London, provides a rather hagiographical and ideologically uncritical general history of a century of BMA moderate medico-politics.

b Paul Vaughan (1959) 'Doctors Commons: a short history of the British Medical Association'. Heinemann, provides a more critical approach to the medico-politics of the BMA yet still, as with most histories of medical politics then (and even now), accepts the conventional anti-quack ideology of the regular organized medical profession whilst failing to differentiate between professionally qualified and licensed but irregular practitioners from unqualified, unlicensed irregular practitioners.

100. Some contemporary research regarding levels of commitment and detachment relative to organizational policy-making is suggestive on this matter of participation and location within a voluntary organization.

a Helen P. Gouldner (1960) 'Dimensions of Organizational Commitment'.
Admin. Sci. Q. 4 (Dec.) p.468-87.

b J. G. Houghland (Jr) and J. R. Ward (1980) 'Control in Organizations and the commitment of members'.
Social Forces 59(1) p.85-105.

c D. Knoke (1981) Commitment and Detachment in Voluntary Associations'.
Am. Soc. Rev. 46(2) April p.141-58.

d D. Knoke and J. R. Wood (1981) 'Organized for Action: commitment in voluntary associations'. Rutgers University Press.

e R. A. Styskal (1980) 'Power and Commitment in Organizations: a test of the participation thesis'.
Social Forces 58(3) March p.73-84.

Let us bear in mind, though, that 19th century GPs in Britain were in a situation of ambiguity regarding their status. Their self-organization can be interpreted as partly a response to this ambiguity. Dr. Kenneth F. Boulding says in his (1953) 'The Organizational Revolution: a study in the ethics of economic organization'. Harper and Bro.
''Organization formalises the status of an individual and hence makes him more secure . . . By formalising an individual's position the status may be improved and rendered more apparent; uncertainty of status is in itself a painful position for an individual to be in'' (p.18-19).

101. I. Waddington (1979) op.cit. p.293-94.

102. op.cit. p.299.

103. op.cit. p.301.

104. See almost any volume of 'The Lancet' from 1834 onwards for examples of this 'anti-quack' ideological 'unity', e.g. Vol. 1 1834-1835 p.359-60; Vol. 1 1836-37 p.142-44, 176, 261-62; Vol. 2 1836-37 pp.74-81, 142-43; Vol. 1 1842-1843 p.688 and so on. This is not to argue that 'ideological unity' was 'ideological uniformity' or 'a monolithic value consensus'. It is to indicate, though, the dominant ideological position in the medical press of the regular practitioners towards those they regarded as medical 'heretics' and 'apostates' (to use theological-political terms).

105. I. Waddington (1979) op.cit. p.289, 302, 303, 316.

106. J. C. Berlant (1975) op.cit. ch. 4 esp. p.154-76.

107. Op.cit. p.159.

108. Op.cit. p.158.

109. See 'Times' correspondence collected in the work by the Homeopath. J. H. Clarke MD (ed) (1888) 'Odium Medicum and Homeopathy'. Homeopathic Pub. Co. London, which gives definite indication of the view of the regular medical 'establishment' and those of the public who accepted its anti-quack ideology.

110. Berlant (1975) op.cit. p.166-67.

111. Op.cit. ch. 5, esp. 207-52.
Also W. G. Rothstein (1972) op.cit. ch. 4-6.

112. A. Giddens (1979) op.cit. p.80.

113. A. Giddens (1979) ibid. p.76ff.
Note that Giddens distinguishes 'social integration' from 'system integration'. Social integration refers to the systemness of social practices at the level of face-to-face interaction. System interaction refers to the systemness of social practices at the level of relations between social systems or collectivities. Thus . . .
''Systemness on the level of social integration typically occurs through the reflexive monitoring of action in conjunction with the rationalization of conduct . . . [and that] . . .the systemness of social integration is fundamental to the systemness of society as a whole. System integration cannot be adequately conceptualized via the modalities of social integration; none the less the latter is always the chief prop of the former, via the reproduction of institutions in the duality of structure'' (ibid. p.77).

114. The issue of the suppressed homeopathic returns during the 1854 cholera epidemic will be discussed and described in detail in chapter 5.

115. B. Holzner and J. H. Marx (1979) 'Knowledge Application: the Knowledge System in Society'. Allyn and Bacon Inc., esp. ch. 5 and 6.

116. N. D. Jewson (1976) 'The disappearance of the Sick-man from medical cosmology, 1770-1870'.
Sociology 10, p.225-44.

117. M. S. Larson (1977) op.cit. p.(xvi).

118. Op.cit. p.(xvii).

119. idem.

120. Op.cit. p.13.

121. idem.

122. Op.cit. p.14.

123. For more detail on 'symbolic universes' see P. Berger and Luckmann (1967) op.cit. p.110-46.

N.B. Oversimplifying the matter we can say that industrial capitalism sustained three basic phases: (a) early laissez-faire, (individualistic and entrepreneurial) capitalism from about the late 18th century to the 1840s, followed by (b) a transitional phase from about the 1840s-70s. This was concluded by (c) an early liberal, collectivist phase from about the 1870s-1920s, followed by the State capitalism of the post WWI era.
For further historical details of this cognitive and institutional shift see Karl Polanyi (1957) 'The Great Transformation: the political and economic origins of our time'. Beacon Press (esp. chapters 4, 6, 10, 12 and 14).

124. M. S. Larson (1977) op.cit. above p.17.

125. Op.cit. p.31.

126. idem.

127. Op.cit. p.32.

128. idem.

129. Bearing in mind that such 'consensus' does not either assume perfect social or system integration, or deny the existence of conflict within and between specialised medical groups.

130. M. S. Larson (1977) op.cit. p.32.

131. This includes the research oriented bio-medical disciplines and clinical-professional disciplines. The criteria and values of the former are mediated to the patient through the techniques and tools of the latter as practised by 'doctors'.

132. M. S. Larson (1977) op.cit. p.32. The term 'paradigmatic' as used by Larson refers specifically to T. S. Kuhn's work in this area. It needs to be stated here that my inclusion of such a term should in no way prejudice its meaning. To my mind it refers to the increasing integration, coherence, fruitfulness, simplicity and predictive capacity of medicine at ontological, epistemological and methodological levels, issuing in a distinctive medical 'cosmology' with a characteristic set of practices in diagnosis, prognosis and therapy.
A paradigm provides a conceptual and technical unity of exemplary theoretical and technical tools, rooted in a wider vision, 'cosmology' or 'world-view'. This wider world-view provides a necessary general ontology, epistemology and methodology for specific research disciplines. We might say it creates a unity of vision and gives direction to the research activities of practitioners by orienting them a

particular way. However, in no way does that unity imply a monolithic uniformity of thought and practice. Each discipline constructs its own conceptual scheme with its appropriate practices through an ongoing and reciprocal dynamic with its object-world, via the conceptual and technical tools appropriate to its domain of research.
In Giddens (1979) terms a 'paradigm' is a conceptual and technical structuration in continuous process of being produced, reproduced and changed by its originators and practitioners. This reproduction and alteration occurs in continuous critical negotiation between the relevant community of practitioners of any specific discipline and the empirical-theoretical experimentation they practice in relation to their relevant object-world. Whether one has a 'realist' or 'instrumentalist' philosophy of science regarding the previous description is methodologically irrelevant to the point I am making about the dynamics of paradigm creation and maintenance.

133. M. S. Larson (1977) op.cit. p.34.

134. idem.

135. cf. R. H. Shryock (1948) op.cit. p.164.

136. M. S. Larson (1977) op.cit. p.36.

137. Op.cit. p.37.

138. cf. Paul de Kruif (1930) 'Microbe Hunters'. Jonathan Cape. First published 1927) particularly chapters III on Pasteur (p.65-116) and IV on Koch (p.117-59)

139. Koch's Postulates:
(i) A specific microbe must be shown to be present in all cases of the disease;
(ii) It must be able to be isolated and cultured in a pure state as an artificial medium (e.g. agar or agar substrates);
(iii) When healthy, susceptible animals are inoculated with the pure culture the disease must be produced in them (i.e. postulates (i) and (ii) be applicable to it).
See Sally Smith Hughes (1977) 'The Virus: a history of a concept'. Heinemann, p.11-15 for an excellent summary of Koch's work in microbiology during the late 19th century and some of the problems it came up against.

140. S. S. Hughes (1977) op.cit. p.14-15.

141. J. R. Ravetz (1973) 'Scientific Knowledge and its social problems'. Penguin. Part II 'The achievement of scientific knowledge', pp. 69-240 but especially pp.181-240.
For a more sociological approach see:
G. N. Gilbert (1976) 'The Transformation of Research findings into Scientific Knowledge'.
Social Studies of Science, vol. 6, p.281-306.

142. 'Everydayness' is a term taken from ethnomethodological work on the taken-for-grantedness of the 'rules' of social interaction.
cf. A. J. Weigert (1981) 'Sociology of Everyday Life'. Longman, especially ch. 3 'Social reality and everyday life', p.109-54.

REFERENCES TO CHAPTER 2

1. Rosa Waugh Hobhouse (1961) 'Christian Samuel Hahnemann - a short biography'. C. W. Daniel & Co. Ltd.

2. W. G. Rothstein (1972) op.cit. p.243-46 points out that the shift from interpreting the law of similars as a causal law of cure, to a methodological practice of drug selection, occurred in 1899 when the American Institute of Homeopathy was redefining the place and role of homeopathy in the whole history of medical theory and practice. By this time the original core formulations of Hahnemann were virtually ignored in practice. This was because the Institute was in a totally new situation regarding the practice of 'orthodox' medicine. Antiseptic surgery, anaesthesia and bacteriological medicine were fruitful and triumphant. The pursuit of a career in homeopathy and the institutions was limited and many were practising a syncretistic/eclectic homeopathic medicine, whilst pursuing regular medical specialisations which did afford advancement.

3. Samuel Hahnemann coined the terms 'allopathic' and 'homeopathic' to focus upon what he considered to be their central therapeutic difference. The neologism of 'homeopathic' came from the two Greek terms 'homoeo' meaning 'like' or 'similar' and 'pathos' meaning 'suffering'. This referred to the principle of similars as a methodology of drug selection, i.e. to select a drug which produces in a healthy person a symptomology (or drug-picture) similar to that produced by the illness in the sick person.
The term 'allopathic' is from the two Greek terms 'allos', meaning 'against' or 'unlike' and 'pathos' meaning 'suffering'. Thus Hahnemann interpreted medical orthodoxy as using a principle of 'dissimilars' in its drug selection for therapeutic practice. 'Allopaths', he claimed, chose drugs whose symptomological 'picture' was antagonistic to the symptoms of the ill person. Also, neither did they 'test' them on anyone except ill people in the course of their practice. Thus they could not gain a true picture of the real effects of the drug, since the patient was debilitated to begin with.

4. W. G. Rothstein (1972) 'American Physicians in the Nineteenth Century: from sects to science'. John Hopkins University Press, p.158 referencing the pro-homeopathic physician-historian William Harvey King, who edited several volumes of 'History of Homoeopathy' (1905). Rothstein refers to Vol. 1, p.44-45 of King.
Rothstein's is an excellent work in many ways. Its strength, however, is also its weakness. He advances an institutional, economic and behavioural model to explain the rise and fall of Homeopathy, Thomsonianism, Eclecticism and other non-mainstream medical practices in the USA. However, I think he pays less than justice to the significance of the ideological warfare and

its institutional-occupational basis between 'regular' practitioners and others.
Ideology is not regarded by me as an epiphenomenon of an institutional-economic base, or a substratum of professional 'behaviour' but a phenomenon in its own right, interacting with, shaping and being shaped by economic, institutional and other processes.

5. Lester King (1958) 'The Medical World of the Eighteenth Century'. University of Chicago Press, ch. IV p.170-73.

6. It was Constantine Hering who, with a number of other German homeopaths, emigrated to the USA in 1835 and helped significantly the teaching, organization and further diffusion of homeopathic medicine.
cf. W. G. Rothstein (1972) op.cit. p.158.

7. R. W. Hobhouse (1961) op.cit. p.22.

8. Wilhelm Ameke M.D. (1885) 'History of Homeopathy: its origins, its conflicts', trans. A. E. Drysdale M.D., edited by R. E. Dudgeon, pub. by E. Gould & Son, p.185.

9. Op.cit. p.143.

10. R. W. Hobhouse (1961) op.cit. p.19-21.

11. Op.cit. p.30.

12. Op.cit. p.31.

13. W. Ameke M.D. (1885) op.cit., editor's preface, p.v.

14. cf Chapter 5; section 5.6.1.

15. Dr. D. R. Livingston 'The Importance of Samuel Hahnemann in the History of Medicine'.
Homeopathy. Vol. 31 No. 7/8, July/August 1981, p.93.

16. F. H. Garrison, A.B., M.D. (1917) 'An Introduction to the History of Medicine', 2nd ed. revised and enlarged.
W. B. Saunders Co., p.306-307.

17. ibid. p.308-311.

a Brunonianism: was the product of John Brown (1735-88) who was a pupil of William Cullen (1712-90). However, Brown pushed Cullen's nerve force theory of disease causation to its absurd limits. Cullen had developed this theory from that of Albrecht von Haller's (1708-77) regarding 'irritability' (i.e. contractility) as being located in the muscle tissue. supplied with nerves. Brunonianism held that health and illness were products of the 'irritability' (i.e. physical excitation of the body) of living organisms. Too much, or too little

'irritability' caused illnesses of a 'sthenic' (i.e. too much irritability) or 'asthenic' (i.e. too little irritability) nature. Diagnosis was the establishing of whether the disease was local or general, sthenic or asthenic, and to what degree. Treatment consisted of either stimulating or depressing the condition. Opium and alcohol were Brown's favourite therapeutic agents. His system gained little support in France and England. However, Benjamin Rush (1745-1813) took it up in the United States and modified it to his own interests. Rush allied his modified Brunonianism with copious bloodletting in the Sydenham tradition (cf. F. H. Garrison (1917) op.cit. p.281-83).

b Broussaisism: created by Francois-Joseph-Victor Broussais (1772-1832) from a modified Brunonianism which focused the Brunonian theory of irritability upon the iatro-chemical notion of heat, which excites the chemical process in the body. Disease, however, was a localised irritation of some viscus tissue or organ (particularly the stomach or intestines). Thus, gastro-enteritis became the basis for all his pathology. Since he was not a supporter of the 'vis medicatrix naturae' he advocated active intervention therapies. He used a heroic, anti-phlogistic and debilitating therapeutic regime, the main remedies being deprivation of the patient's proper food, and intensive leeching. His arbitrary doctrines were finally overthrown by the rise of the Paris Clinical-Hospital School, particularly the statistical work of his pupil, Pierre-Charles Alexandre Louis (1787-1872) and the sensible clinical judgements of Chomel.

18. E. W. Ackerknecht (1967) 'Medicine at the Paris Hospital 1794-1848'. Johns Hopkins Univ. Press.

19. W. Ameke (1885) op.cit. p.76.

20. idem.

21. Op.cit. p.56.

22. Conditions such as theoretical pluralism, professional sectarianism, epistemic dogmatism, internal market competition, cognitive uncertainty and lack of a body of medical knowledge which was intersubjectively and empirically testable across all schools of thought and able to be taught via a standardized educational system. Such conditions only emerged under the collapse of Heroic medicine and the formation of the Clinical-Hospital and then Bacteriological-laboratory research programmes.

23. W. Ameke (1885) op.cit. p.76.

24. Irish Hom. Society. C. W. Luther ed. (1848) 'A Concise View of the System of Homeopathy, and Refutation of the Objections Commonly Brought Forward Against It'. James McGlashan, Dublin; William S. Orr & Co., London, p.13.

25. William Cullen (1710-90) 'Materia Medica', Vol. 1, p.58. A pupil of Alexander Monro (primus) (1697-1767) and one of the founders of the Glasgow Medical School in 1744. Cullen was professor of medicine and chemistry at Glasgow and Edinburgh during his lifetime. He was the first to lecture in the vernacular (1757) instead of Latin. He was considered by the medical historian Garrison to have been a better teacher than a clinician due to his more philosophical approach to medical theory. Cullen added little to the body of medical knowledge. He was a follower of the theory that organic phenomenon developed from the nerve force or its disorders. He modified the Glissen-Haller doctrine of irritability by considering muscle as a continuation of nerve and regarding life itself as simply a function of nervous energy (F. H. Garrison (1917) op.cit. pp.307, 357-58, 404-405).

26. W. G. Rothstein (1972) op.cit. p.152.
Also W. Ameke, M.D. (1885) passim.

27. Paracelsus (1493-1541) ie Aureolus Theophrastus Bombastus von Hohenheim, was founder of chemical pharmacology and therapeutics. Hahnemann's affinity to his work was explicable, gives his own interest on experimental chemistry, pharmacology and therapeutics and that both of them were 'wanderers' and persecuted by the authorities from time to time. Their attitude to opponents was certainly similar.
Paracelsus' doctrine of signatures was based upon the belief that some associative resemblance between the remedy and the disease was the principle of drug selection (e.g. walnut shells for head injuries, thistle for a 'stitch' in the side). However, Hahnemann's substantive content to his conception of similia was very different. It was empirically based upon total symptomology and the pathology of therapeutic pharmacodynamics. In short, it was a biochemically based principle, whereas Paracelsus' was more one of some physical association between remedy and the morbid organ.

28. These historical analogies were only in the first three editions of the 'Organon' and were reproduced by the Irish Homeopathic Society in their publication of (1848) 'A Concise View of the System of Homeopathy, and Refutations of the Objectives Commonly Brought Forward Against It', op.cit. p.27-43. We shall return to this interesting document later in discussing the ways Homeopaths defended themselves.
The work itself is an excellent example of how the conflict between medical and ideological opponents can become ritualized, routinized and rendered stagnant as far as rapprochement was concerned.

29. W. G. Rothstein (1972) op.cit. p.154.

30. idem . . . . quoting Hahnemann's (1949) 'Organon of Homeopathic Medicine' 3rd American Edition, pub. by William Radde, p.204-205.

31. Harris L. Coulter (1972) 'Homeopathic Medicine'. Formur International, p.34.

32. W. G. Rothstein (1972) op.cit. p.155.

33. Homeopaths use the Decimal or Centecimal scale of dilution. Thus:-
1 X (Decimal) is one part solid or tincture mixed with (or ground in with) nine parts of milk sugar.
2 X is taking 1 part from the 1 X dilution and mixing it with 9 parts milk sugar,
and so on. Performing same operations, in same proportions up to 24 X and beyond.
1 C (Centecimal) is 1 part solid/tincture to 99 parts milk sugar, alcohol, or distilled water.
2 C is taking 1 part from 1 C dilution and mixing with 99 parts milk sugar, alcohol, or distilled water,
and so on. Performing same operation, in same proportions up to 12 C and beyond.
Beyond 24 X and 12 C dilutions (the 'Avagaddro Limit') there is statistically taken to be no single molecule of material substance of original solid or tincture in the dilution (assuming an homogenous mixture is achieved at each stage). Homeopathic pharmacists frequently use remedies of 30 X or 200 X which are well beyond this statistical limit. Hence regular practitioners charge them with just giving placebos to their patients (i.e. pharmacologically non-active drugs). However, recent experiments with dilutions ranging from 10 to the power of -27 to 10 to the power of -402 have shown them to still be reactive with other substances.
cf. J. Stephenson J. Am. Inst. Hom. 48 (1955) p.327-355, and J. Stephenson and G. D. Barnet J. Am. Inst. Hom. 62 (1969) p.73-85.

34. G. Rankin (1980) 'Homeopathy - popular medicine or science?' unpublished Ms. Keele University Dept. Sociology and Social Anthropology. It only covers 1800-1850.

35. W. G. Rothstein (1972) op.cit. p.239-43. The details of this internal conflict will be dealt with later.

36. Imre Lakatos (1970) 'Falsification and the Methodology of Scientific Research Programmes', p.91-196. especially section 3, p.132-138; The idea only is used by me, not his theory of SRPs, in I. Lakatos and A. Musgrave (eds) (1970) 'Criticisms and the Growth of Knowledge'. Cambridge University Press.

37. a W. G. Rothstein (1972) op.cit. p.157.
b Irish Hom. Soc. C. W. Luther ed. (1848) op.cit. ch. 2, p.24-27.

38. W. G. Rothstein (1972) op.cit. p.157.

39. These terms, relating to the various aspects of Hahnemann's general philosophical foundation and medical theorizing should be understood to be broad orientational concepts only, rather than logically precise conceptual definitions. However, he was certainly a Deist, a dualistic transcendental pneumaticist in his overall philosophy. His philosophy of medicine was a mixture of transcendental chemistry, iatro-analytical chemistry, organismic (non-reductive) vitalism and naive empiricism.

40. L. S. King, op.cit. p.158.

41. Op.cit. p.186.

42. Op.cit. p.187.

43. Op.cit. p.183-84.

44. Such an assessment would depend upon which philosophy (or philosopher) of science one supported. 'Ad hoc' strategies are evaluated by some as, in principle, a mark of 'bad' science (e.g. Karl Popper) or a necessary condition for any new scientific theory to survive (e.g. Imre Lakatos and Thomas Kuhn) or, neither 'good' or 'bad' just part of the game of anything goes in science (e.g. Paul Feyerabend).

45. W. Ameke (1885) op.cit. p.v.

46. a. 'The Opposition to Homeopathy'. Brit. J. Hom. 30(120) p.209-39. 1872.

b. 'The Homeopathic Schism'. Dr. Richardson, F.R.S. in 'The Lancet' (1877) Vol. 1 June 2, p.816-17.
The Lancet's comments on Richardson's article are of interest (cf. p.811) in that only total renunciation of homeopathy in name and deed is the basis for acceptance back into the ranks of 'legitimate practitioners'.

c. 'The Lancet' July 16, 1881, Vol. 2 p.107-108, reporting on the BMA Presidential Address of Dr. Jenks.
The Lancet used it as an opportunity to remind the BMA of its 1851 conference in Brighton (it was the Prov. Medical and Surgical Assoc. then) when it regarded homeopathy as infringing three criteria of good medicine - <u>science,</u> <u>common sense</u> and the <u>experience</u> of the medical profession.

d. John H. Clarke, M.D. 'The Jubilee Meeting of the British Medical Association'.
Brit. J. Hom. 40(162), p.382-89 (1882).
The above are only a small sample of the kinds of things being said about homeopathy, as seen from both camps of medical practice. See chapter 5 for detailed exposition of some of this ideological conflict literature in the British context.

47. Christian Wilhelm Hufeland (1762-1836).

A philanthropic physician and professor of medicine who was one of the pioneers of medical journalism in the 18th century. He edited four journals, the most important being the 82 volumes of the 'Journal der praktischen Arzneikunde' (1795-1836) known as Hufeland's Journal. He also seems to have helped clear up popular misconceptions about various medical practices, including some 'fringe' ones of the day, e.g. Mesmerism and Phrenology.
cf. Garrison (1917) op.cit. p.368-69.

48. W. Ameke (1885) op.cit. p.172-73.

49. Op.cit. p.173.

50. Op.cit. p.183.

51. D. A. F. Heckner's critique of the 'Organon' in 1811.
cf. Ameke (1885) op.cit. p.180ff.

52. R. W. Hobhouse (1961) op.cit. p.22.

53. W. Ameke (1885) op.cit. p.185.

54. Anonymous Author (a Dr. Meisnner perhaps) (1824) 'Works of Darkness in the Domain of Homeopathy'. A concoction of gossip, ad hominem arguments and 'horror stories' about Hahnemann and the homeopathists referred to in Ameke (1885) op.cit. p.185ff.

55. Dr. Rua (1828) 'On the Value of Homeopathic Treatment' referred to by Ameke (1885) op.cit. p.185ff.

56. L. S. King (1958) op.cit. p.169.
Hahnemann's experience with the European Scarlet Fever Epidemic of 1799 led him to the advocacy of dilutions in order to increase their curative effectiveness.

57. L. S. King (1958) idem.

58. R. W. Hobhouse (1961) op.cit. p.31.

59. idem.

60. Synopsis only of Ameke (1885) op.cit. p.186ff.

61. W. Ameke (1885) op.cit. p.253-254.

62. Ameke (1885) op.cit. is prone to this at times. But he does also report sources contemporary at the time (early 19th century) which also displayed rather eschatological views of Homeopathy and its supposed effects upon 'Rational Medicine'. These basic attitudes and positions were reproduced decades later in Britain and the United States.

a e.g. James Young Simpson (1853) 'Homeopathy: its tenets and tendencies, theoretical, theological and therapeutical'. Edinburgh.
b Oliver Wendell Holmes (1842) 'Homeopathy and its Kindred Delusions' in 'Medical Essays' (1891) by Sampson, Low, Marston Searle and Rivington, p.3-102.
c Worthington Hooker (1851) 'Homeopathy: an examination of its doctrines and evidences'. Charles Scribner.

63. a L. S. King (1958) op.cit. p.184-85.
b W. G. Rothstein (1972) op.cit. p.156.

64. Further sociological analysis of the patterns of marginalization and stigmatization will be more fully elaborated from this and the following work in Chapter 6.

REFERENCES TO CHAPTER 3

1 a L. S. Bryan (Jr.) (1964) 'Bloodletting in American Medicine 1830-1892'.
Bull Hist. Med. 38 p.516-24.

b P. H. Niebyl (1977) 'The English Bloodletting Revolution, or modern medicine before 1850'.
Bull Hist. Med. 51(3) p.464-83.

2. G. B. Risse (1979) 'The Renaissance of Bloodletting: a chapter in modern therapeutics'.
J. Hist. Med. 34 p.3-22.

3. E. H. Ackerknecht (1967) 'Medicine at the Paris Hospital 1784-1848'. Johns Hopkins Press.

e.g. Francois Joseph Victor Broussais (1772-1838) studied clinical physiology under Philippe Pinel (1745-1802) and Marie Francois Xavier Bichet (1771-1802) but rejected their 'expectant' therapeutics as based upon an arbitrary medical ontological nosography. Broussais proposed an active anti-phlogistic, physiological medicine which included local leeching. cf. ch. 5, p.47-58.

4. Op.cit. ch. 8 p.101-113, which includes clinicians such as Chomel (1788-1856), Louis (1787-1872) and Andral (1747-1876) but affected only the period from about 1830 to 1848 in the Paris School

5. 'Expectant Therapy'. This was formulated as a response to Heroic practices on the basis of the knowledge derived from Clinical-Hospital medicines. It was a set of non-heroic practices based upon philosophical and clinical scepticism regarding previous heroic therapies. Some of its advocates emphasised healing by the natural processes of the body where possible, use of good diet, fresh air, sunlight, palliation of pain with quinine and conservatory surgery. Sir John Forbes' work of 1857 'Nature and Art in the Cure of Disease', John Churchill, is an excellent exposition of this position. It received an answer from the homeopath Robert M. Theobald, M.A., M.R.C.S. in (1859) 'Homoeopathy, Allopathy and Expectancy', Leath & Ross, London.
Forbes considered Expectant Therapy to be of two kinds: (a) Rational or Auxiliary, in which the physician's role was to create the optimum conditions for nature to take its course. This would involve the use of some drugs where required, and (b) Contingent or Pure Expectancy, in which nothing was done at all. He judged 'regular' clinical physicians to be using the rational form and homeopaths the contingent form of expectant therapy. Theobald regarded such a distinction as valid but its designation regarding the homeopaths as based upon ignorance of homeopathic therapeutics.

6. W. G. Rothstein (1972) 'American Physicians in the Nineteenth Century: From Sects to Science'. Johns Hopkins University Press, p.186-197.
Rothstein also discusses 'The Demise of Heroic Therapeutics' p.181-83, and 'Therapeutic Nihilism', p.183-186.

7. W. G. Rothstein (1972) op.cit. p.185.

8. a N. D. Jewson (1976) 'The Disappearance of the 'sick man' from medical cosmology' 1770-1870.
Sociology 10, p.225-44.
b Judy Sadler (1970) 'Ideologies of 'Art' and 'Science' in Medicine' in Krohn, Layton & Weingart (eds) (1978) 'The Dynamics of Science and Technology', Reidel Pub., p.177-215.

9. In the U.K. it was directed and focused by the English Homeopathic Society founded by John Epps (1805-69). It was set up in opposition to the 'professionals' of the British Homeopathic Society, founded by Frederick Hervey Foster Quin (1744-1878), in 1844. In the U.S.A. the lay homeopathic movement was more diffuse and less organized in terms of representative central administrations existing (cf. W. G. Rothstein (1972) op.cit. ch. 12 p.230-31) but it nonetheless contributed generally to the eventual conflict between 'high' and 'low' dilutionists amongst 'professional' homeopaths (cf. Rothstein (1972) op.cit. ch. 12 p.239-243.

10. Please see Chapter 6 for a working definition of 'power' and 'domination'
The second level of analysis will be based upon selections from the history of homeopathy in the U.S.A. and Britain with emphasis given to areas of conflict between regulars and homeopaths over specific issues. The third aspect will be a sociological study of such issues.

11. a Eric Jameson (1961) 'The Natural History of Quackery'. Michael Joseph Ltd.
He defines 'quackery' as characterized by 'the principle of self-advertisement' (p.18) but if applied consistently that would render 'regular practitioners' as quacks for most of the history of medicine. After all, there were many ways of 'advertising' oneself before advertising in newspapers came along. In applying his definition to certain claimed 'quacks', some of whom were regular M.D.s, he becomes self-refuting. cf. p.20-22.
b W. R. Steiner M.D. (1926) 'The Conflict of Medicine with Quackery'.
Annals Med. History 6, p.60-70, defines medical quackery, quite differently from Jameson (1961), as 'that mode of practising medicine which takes one idea and applies it to all kinds of diseases without reference to their origin, or administers one remedy for all possible diseases' (p.60). That definition would again have to include the 'regular' medicine as practised for much of its history, especially if we keep to its practical therapeutic aspects.

c Morris Fishbein M.D. (1932) 'Fads and Quackery in Healing'. Blue Ribbon Bks. Inc. provides a characteristic non-substantive, purely psycho-social description of 'charlatans'. This is another term for 'quack' but emphasises the 'confidence-trick' aspects of 'deviant' medicine, which has more to do with the stereotype of the nostrum vendors and travelling grocers of the frontier days of the U.S., than a disinterested study of 'professional' practitioners of alternative medical systems.

12. A virtual world-and-life view.

13. a T. S. Kuhn (1970 2nd ed. enlarged) 'The Structure of Scientific Revolutions'. Univ. of Chicago Press.
Paradigm: Taken in the sense of being both metaphysical frameworks which provide a general epistemology and methodology for practitioners, or exemplary works of theory and/or practice to be emulated. This has often taken the institutional form of 'schools' of thought either founded by a charismatic leader or created by the collective work of theoreticians and skilful practitioners operating within a particular discipline but moulding it into a distinctive perspective and practice. If Kuhn's chapter 7-10 are read in conjunction with E. W. Ackerknecht's (1967) 'Medicine at the Paris Hospital, 1794-1848' my proposed view of a 'paradigm' will be adequately communicated, with a little historical imagination.

b I. Lakatos (1970) 'Falsification and the Methodology of Scientific Research Programmes'.
In I. Lakatos and A. Musgrave (eds) (1970) 'Criticism and the Growth of Knowledge'. C.U.P., p.91-196.
Scientific Research Programme: Taken in the sense of the existence of a 'hard core' of fundamental assumptions. However, I would propose that for an applied 'science' like 'professional' medicine, the 'hard core' also contains a set of therapeutic practices, protected by an 'auxiliary belt' of ad hoc hypotheses which can enlist the aid of the medical traditions or auxiliary medical disciplines for purposes of ad hoc defensive measures. Coupled with his notions of 'monster barring', 'exception barring', 'monster-adjustment' and 'concept-stretching' (in Lakatos' (1976) 'Proofs and Refutations' C.U.P.), interesting perspectives can be employed to analyse the stigmatizing strategies and tactics of the 'regulars'.

c Larry Laudan (1977) 'Progress and its Problems: towards a theory of Scientific Growth'. R.K.P.
Research Tradition: Taken in the sense of being an historically and substantively identifiable ensemble of certain metaphysical and methodological commitments which are exhibited via a variety of specific theories and partially constituted by those same theories during definite phases of the research traditions development (including its radical reformulations at times). In brief, 'a research tradition is a set of general assumptions about the entities and processes in a domain of

study, and about the appropriate methods to be used for investigating the problems and constructing the theories in that domain' (Laudan (1977) p.81). Or, put simply, it is 'a set of ontological and methodological 'do's' and 'don'ts .' (p.80). At this general level of ontology and methodology a research tradition is 'neither explanatory, nor predictive, nor directly testable' (p.81-82). These are the characteristics of its constituative theories. Within medicine we can identify the research traditions of Pneumaticism, Humoralism and Solidism which were expressed in culturally specific ways during different historical periods of societal development. For example the Solidism of Asclepiedes of Bithynia can be traced through to its formalisation by his pupils and adherents in Methodism. Also its guises in Broussais' theory of irritation as the cause of disease, and Rosari's doctrine of stimulus and contrastimulus.

d J. R. Ravetz (1973) 'Scientific Knowledge and its Social Problems'. Penguin Books.
Folk Science 'is part of a general world view, or ideology which is given special articulation so that it may provide comfort and reassurance in the face of the crucial uncertainties of the world of experience' (p.386). 'Immature sciences are . . . . more closely related to folk sciences' (p.389) and 19th century therapeutics was certainly immature for much of the century. This was due to two main factors: (a) its intrinsic multi-variable complexity and (b) its paucity of empirically 'objective' knowledge (i.e. inter-subjectively testable, experimentally derived data).

14. N. D. Jewson (1976) op.cit. p.225-226.

15. Op.cit. p.226.

16. Anthony Giddens (1979) 'Central Problems in Social Theory: action, structure and contradiction in social analysis'. Macmillan Press Ltd., p.218-19, where he says that ontological security is premised upon effective tension management (i.e. reduction and control of anxiety) during the formation of ego-identity. These modes of tension management are most effective when they are least noticed in their influence upon the routine reflective monitoring of conduct by the agent. 'Ontological security can be taken to depend upon the implicit faith actors have in the conventions' (p.219) of everyday life, which themselves are grounded in the mutual 'stocks of knowledge' social agents refer to in their interaction and discourse.

17. cf. Peter L. Berger (1973) 'The Social Reality of Religion'. Penguin University Books for discussion of 'the nomos' (p.28-34) and 'theodicy' (p.61-87).
This idea receives a more general and more widely applicable formulation in Peter L. Berger and Thomas Luckman (1971) 'The Social Construction of Reality'. Penguin University Books, in their discussion of the legitimation of society as 'objective reality' through the media of symbolic universes

constructed from tradition, discourse, norms and meaning systems.

18. C. E. Rosenberg (1974) 'The Therapeutic Revolution: medicine, meaning and social change in Nineteenth Century America' in M. J. Vogel and C. E. Rosenberg (1979) 'The Therapeutic Revolution: essays in the Social History of American Medicine'. University of Pennsylvania Press, p.3-25.

19. This is subsumed under power and interests in Ch. 6.

20. M. Kaufman (1971) 'Homeopathy in America: the rise and fall of a medical heresy'. Johns Hopkins Press, comments that in 1888 the Massachusetts Medical Society . . . 'voted to allow graduates of homeopathic colleges to be examined for admission to fellowships' on the condition that such candidates 'repudiate homeopathy, publicly renounces every tenet, and practically assert that he had been living in sin', (p.148).

21. a J. R. Ravetz (1973) op.cit. ch. 3 'Science as Craftsman's Work', p.75-108 but especially p.101-103.
b A philosophically extended treatment of the tacit dimension of personal and scientific knowledge is provided in Michael Polanyi's (1958) 'Personal Knowledge: Towards a Post Critical Philosophy'. R.K.P.
(I have used the 1973 paperback version). See his Part Five: The Tacit Component, p.69-245, esp. the section on Articulation p.69-131.

22. Whether this is seen as a career advance is a moot point. It can certainly be rationalized as such but given the immature condition of therapeutics it can be equally explained as one way of resolving cognitive dissonance regarding one's ideals and experience of actual practice in an applied science.

23. A. Giddens (1979) op.cit. p.123-128.

24. a T. S. Kuhn (1970) op.cit. ch. 7-10.
b Peter L. Berger (1961) 'The Precarious Vision'. Doubleday and Co. Inc.
c Peter L. Berger (1966) 'Invitation to Sociology'. Pelican Books, p.68-80.
d Peter L. Berger and Thomas Luckman (1967) op.cit. p.166-182.
e Peter L. Berger (1973) op.cit.

25. a K. Jones (1977) 'Some epistemological considerations of paradigm shifts: basic steps towards a formulated model alternation'.
Soc. Rev. 25(2) p.253-71.
b K. Jones (1978) 'Paradigm shifts and identity theory: alternation as a form of identity management'.
Hans Mol (ed) (1978) 'Identity & Religion'. Sage Pub. Ltd., p.59-82.

c B. L. Hardin and G. Kehrer (1978) 'Identity and Commitment'. Hans Mol (ed) (1978) op.cit. p.83-96.
d Eileen L. McDonagh (1976) 'Attitude changes and paradigm shifts: social psychological foundations of the Kuhnian thesis'. Soc. Stud. Science 6 p.51-76.

26. David A. Snow and Richard Machalek (1983) 'The Convert as a Social Type' in R. Collins (ed) (1983) 'Sociological Theory 1983'. Josey Bass Pub., p.259-89.

27. William Shaffir (1978) 'Witnessing as Identity Consolidation' in Hans Mol (1978) op.cit. p.39-57.

28. R. N. Stromberg (1975) 'An Intellectual History of Modern Europe'. 2nd ed. Prentice-Hall Inc., p.200.

29. a B. Barnes (1974) 'Scientific Knowledge and Sociological Theory'. R.K.P.
b B. Barnes (1977) 'Interests and the Growth of Knowledge'. R.K.P.
c D. Bloor (1976) 'Knowledge and Social Imagery'. R.K.P.

30. a E. H. Ackerknecht (1962) 'Aspects of the history of therapeutics' Bull Hist. Med. 36(5) p.389-419.
b A. Berman (1954) 'The Heroic approach to nineteenth century therapeutics'. Bull. Am. Soc. of Hospital Pharm. Sept.-Oct., p.312-27.
c G. H. Brieger (1967) 'Therapeutic conflicts and the American Medical Profession in the 1860s'. Bull. Hist. Med. 41(3) p.215-22.
d W. G. Rothstein (1972) op.cit. ch. 3 p.41-62; ch. 9 p.177-97.
e M. J. Vogel and C. E. Rosenberg eds. (1979) 'The Therapeutic Revolution'. University of Pennsylvania Press.

31. a L. S. Bryan (Jr.) (1964) 'Bloodletting in American Medicine 1830-1892'. Bull. Hist. Med. 38 p.516-29.
b L. S. King (1961) 'The Bloodletting controversy: a study in scientific method'. Bull Hist. Med. 35(1) p.1-13.
c P. H. Niebyl (1977) 'The English Bloodletting Revolution, or modern medicine before 1850'. Bull Hist. Med. 51(3) p.464-83.
d G. B. Risse (1979) 'The Renaissance of Bloodletting: a chapter on modern therapeutics'. Jour. Hist. Med. 34 p.3-22.
e J. H. Warner (1980) 'Therapeutic explanation and the Edinburgh Bloodletting Controversy: two perspectives on the medical meaning of science in the mid-nineteenth century'. Med. Hist. 24 p.241-58.

32. a Humoralism was based upon the Hippocratic idea that morbid conditions of the human organism were due to disturbances of the humours or body fluids (i.e. blood, yellow bile, phlegm and black bile). Health was premised upon the equilibrium of these fluids. Hence, illness was the disequilibrium of the body's humours. The physician's function was to intervene in such a way as to maximize the natural ability of the body to restore equilibrium.

b Solidism was the Aesclepian idea that disease was due to the constricted or relaxed condition of the body in relation to its solid particles. This idea derived from Democratius' atomic theory of particulate matter and was re-expressed in the culturally specific forms of medical materialism, mechanism and particulate theory, over the centuries, especially since the 17th century 'scientific revolution'.
The physician's role was founded upon the anti-Hippocratic notion of the inefficiency, even inability of the 'vis medicatrix naturae' to actually effect a cure. Thus the radical intervention of the physician was called for to restore health.

33. A. Berman (1954) op.cit. p.321-22.

34. According to Louise Carter, leeches were still being used - unbeknown to patients - in the treatment of Glaucoma in 1938.
cf. Louise Carter (1984) 'The Vampires of the Victorians'. Nursing Times. May 9-15 p.53.

35. M. Kaufman (1976) 'American Medical Education: the formative years 1765-1919'. Greenwood Press, p.58.

36. A. Berman (1954) op.cit. p.321; P. H. Niebyl (1977) op.cit. p.479-81; L. S. King (1961) op.cit. p.1-2; L. S. Bryan (Jr.) (1964) op.cit. p.516, 518, 520 and his appendix p.525-28; G. B. Risse (1979) op.cit. p.3-6; W. G. Rothstein (1972) op.cit. p.177-83.

37. P. H. Niebyl (1977) op.cit. p.465, 479, 472 respectively.

38. Op.cit. p.475. This claim was made by Thomas Sutton in a work of 1806 entitled 'A Practical Account of a Remittent Fever frequently occurring among the Troops in this Climate', p.16-17 quoted by Niebyl (1977) op.cit. and referred to in his note 68 p.474.

39. P. H. Niebyl (1977) op.cit. p.477.

40. W. G. Rothstein (1972) op.cit. p.42.

41. Op.cit. p.43.

42. Op.cit. p.46 and 47.

43. Op.cit. p.48.

44. L. S. King (1982) 'Medical Thinking: a Historical Preface'. Princeton University Press, p.228-229 (but also see his whole ch. 11 'Reflections on Bloodletting', p.227-244). Bleeding, along with purging and vomiting therapies, was a standard practice on those suffering from various nervous disorders and problems. cf. Bryan Crowther (1811) 'Practical Remarks on Insanity' Underwood, p.72-75, 102-106 for bleeding; p.106-108 for purging; and p.108-13 for vomiting therapies.

45. A. Berman (1954) op.cit. p.323-24.

46. a A. Berman (1954) op.cit. p.323-24.
b W. G. Rothstein (1972) op.cit. p.177-83.

47. a A. Berman (1954) op.cit. p.321, 323.
b R. H. Niebyl (1977) op.cit. p.464-65, 471-72, 479-80, 483.
c L. S. Bryan (1964) op.cit. p.517-20.
d W. G. Rothstein (1972) op.cit. ch. 3 p.41-62 and ch. 9 p.177-97.
e G. B. Risse (1979) op.cit. p.3-5.

48. a L. S. Bryan (1964) op.cit. p.522.
b W. G. Rothstein (1972) op.cit. p.50.

49. H. L. Coulter (1973) 'Divided Legacy' Vol. 3 'Science and Ethics in American Medicine 1800-1914', where Coulter says 'Mercury was even found in the bones of skeletons being prepared for demonstrations', p.68, referring to the 'American Homeopathic Observer' Vol. 2 (1865) p.18.

50. Gert H. Brieger (1967) op.cit. p.215.

51. Op.cit. p.221.

52. W. G. Rothstein (1972) op.cit. p.52.

53. Op.cit. p.189.

54. Op.cit. p.54.

55. a C. W. Luther (ed) (1848) 'A Concise View of the System of Homeopathy and Refutation of the Objections Commonly Brought Forward Against It'. James McGlashan, Dublin and William S. Orr & Co., London, p.147-49.
b L. King (1958, reprint 1971) 'The Medical World in the Eighteenth Century'. Robert E. Krieger Pub. Co. Inc., p.167.

56. G. B. Risse (1979) op.cit. p.16.

57. G. B. Risse (1979) op.cit. p.6.

58. L. S. Bryan (1964) op. cit. p.522.

59. Hall was a leading advocate of physical experimentations, especially in the area that we would now call neuro-physiology. cf. F. H. Garrison (1917) 'An Introduction to the History of Medicine' W. B. Saunders Co., p.489-90. For Hall's work on bleeding as a therapy see his 1830 'Researches principally relative to the morbid and curative effects of loss of blood'. E. L. Carey and A. Hart.

60. Louis is regarded as the founder of medical statistics. By their use he demonstrated the uselessness of bleeding in the case of pneumonia, but his study of this disease had an impact of a wider nature upon the practice of venesection. cf. F. H. Garrison (1917) op.cit. p.417-18. For Louis' work on the efficacy of bleeding in pneumonia cases see his 1836 (trans. by C. G. Putnam) 'Researches on the effects of bloodletting in some inflammatory disease . . .' Hilliard, Caray and Co.

61. L. S. Bryan (1964) op.cit. p.518.

62. Op.cit. p.520.

63. Op.cit. p.521.

64. A. Berman (1954) op.cit. p.324, summarising and quoting from the Medical and Surgical Reporter III pp.495-521 and IV p.35 1860 (see Berman's notes 23 to 32 inclusive).

65. Op.cit. p.325.

66. L. S. Bryan (1964) op.cit. p.525-29.

67. a Rothstein (1972) op.cit. p.182,
b and see Sir William Osler (1898) 'Principles and practice of medicine', 3rd edition, Young J. Pentland, p.135, and also in yellow fever (p.188), sunstroke (p.398), emphysema (p.659), heart disease (p.731), arterio-sclerosis (p.775) and cerebral haemorrhage (p.1012).

68. G. B. Risse (1979) op.cit.

69. Op.cit. p.22.

70. Op.cit. p.21.

71. a Derek L. Phillips (1977) 'Wittgenstein and Scientific Knowledge: a sociological perspective'. Macmillan Press Ltd., especially ch. 4 'Relativism and Wittgenstein' p.74-92 and ch. 5 'Paradigms and Incommensurability' p.93-118. Phillips argues that all scientific speciality language-games are based upon the basic language-game of 'everyday-life', which has an ontological and epistemological priority over all other language-games (p.89). Speciality language-games are <u>not</u> totally closed (p.110), nor totally incommensurable with each other (p.112) because they are all

refined from and can be mediated to each other through the common meta-language of the everyday language-game (p.99-105).

b Donald Davidson (1973) 'On the Very Idea of a Conceptual Scheme', p.5-20.
Presidential Address, delivered before the 70th Annual Eastern Meeting of the American Philosophical Association in Atlanta, Dec. 28, 1973.
Davidson identifies conceptual schemes with languages. Given the actual practice of the inter-translatability of languages, he considers the question of commensurability/ incommensurability to be resolved at the practical level of inter-translation by a thesis of partial incommensurability.

c L. Laudan (1977) 'Progress and its problems: towards a theory of scientific growth'. R.K.P.
See his ch. 3 'From Theories to Research Traditions', p.70-120, esp. pp.73-76 for his critique of Kuhn's 'paradigms' and ch. 4 'Progress and Revolution', p.121-51, esp. pp.139-44 for his critique of the incommensurability thesis. Laudan resolves the comparison of different conceptual schemes to one of their adequacy at solving specific conceptual or empirical problems according to a research tradition and comparison with other research traditions. Laudan's problem is actually establishing criteria which make it meaningful to assert that different theories, from different research traditions can be compared on the basis of their attempt to solve 'the same problem'. Therefore, what constitutes 'sameness' and what constitutes a 'problem' in the different research traditions is itself problematic.

72. a D. L. Phillips (1977) op.cit. p.99-105.

b F. I. Dretske (1969) 'Seeing and Knowing', R.K.P., esp. chs. 3 and 4 in which he discusses the issues of perceptual relativity and the relation of observation to scientific practice from a philosopher's perspective. He distinguishes between the conditions for primary epistemic seeing (Wittgenstein's 'seeing') and secondary epistemic seeing (Wittgenstein's 'seeing as').
'Seeing'/'seeing as' are states, whereas 'interpretations' are thinking activities of the mind. However, this makes little difference to the everyday act of 'seeing'. 'Seeing' and 'seeing that' are not existentially separate.

73. L. S. King (1961) op.cit. p.1.

74. J. H. Warner (1980) op.cit.

75. Op.cit. p.242.

76. (i) Institutional displacement
For general development within medicine in line with this proposition see:

a R. H. Shryock (1948) 'The Development of Modern Medicine' Victor Gollanz Ltd. ch. 9-13.

b Rainald von Grzycki (1972) 'Centre and Periphery in the International Scientific Community: Germany, France and Great Britain in the 19th Century'.
Minerva 11 p.474-94.
(ii) Generational elite displacement
a Russell M. Jones (1970) 'American Doctors in paris, 1820-1861: A Statistical Profile'.
Jour. Hist. Med. 25 p.143-57,
and . . .
b Russell M. Jones (1973) American Doctors and the Parisian Medical World, 1830-1840'.
Bull Hist. Med. 47, p.40-65, 177-204.
There was established a period of dominance by the Paris School of Medicine and its students from 1820-60, with a shift to Vienna occurring from the 1850s.Other medical centres were attended, such as London and Vienna, but the Paris School shaped several generations of practitioners in patho-physiological Clinical-Hospital Medicine.
(iii) Theory of generations and the role of 'the past' and 'present' in social change and innovation
see (a) Karl Mannheim (1927) 'The Problem of Generations' in Karl Mannheim (1952) 'Essays on the Sociology of Knowledge' (edited by Paul Kecskemeti) R.K.P., p.276-332, but particularly p.286-320
(b) Edward Shills (1981) 'Tradition' Faber and Faber, for a lucid discussion of tradition in all its varies forms; scientific, religious, literary and their interaction.

77. J. H. Warner (1980) op.cit. p.242-247.

78. Op.cit. p.242-43.

79. Op.cit. p.246-247.

80. Op.cit. p.247.

81. Op.cit. p.244.

82. Op.cit. p.247.

83. Op.cit. p.256.

84. Op.cit. p.257.

85. E. H. Ackerknecht (1967) op.cit. (note 3).

86. L. S. King (1961) op.cit. p.1-2.

87. a J. A. Roth (1976) 'Health Purifiers and their Enemies'.
N. Watson, esp. ch. 4, 5 and 7.
b W. G. Rothstein (1972) op.cit. esp. chapters 7, 8 and 11.
This issue of marginal practitioners is virtually ignored in histories of British medical developments, on any extensive scale of empirical study. But see –

(i) D. Hamilton (1981) 'The Healers'. Canongate, Edinburgh, for the situation in Scotland generally.

(ii) F. Kaplan (1974) 'The Mesmeric Mania: the early Victorians and Animal Magnetism'.
J. Hist. Ideas 35(4) Oct.-Dec. p.691-702.
A marginal, even 'crank science' which by the 20th century became a 'respectable' practice for scientific doctors and psychiatrists to use as part of the tools and methods of treatment already in existence. It had been transformed into 'medical hypnosis'.

(iii) Robin Price (1981) 'Hydropathy in England 1840-70'.
Med. Hist. 25 p.269-280.
Price still falls victim to the seduction of the regular profession's historically constructed anti-quack ideology when he judges that 'the views of the 'Lancet' and the profession rested on well-tried principles while the enthusiasm of the hydropathists rested on pragmatic success' (p.275). To pose the issue as one of (rational?) principles versus (empiric?) pragmatic success is to ignore the mutually interactive nature of reason and experience in the production and reproduction of knowledge. After all, under the principle of the vis medicatrix naturae, hydropathy as a therapy was incorporated into regular practices.

(iv) F. B. Smith (1979) 'The People's Health 1830-1910'. Croom Helm, London.
But, his evaluations of hydropathy and homeopathy (p.342) are still enmeshed in uncritical repetition of the regular profession's anti-quack ideology regarding them.

(v) Although phrenology has received extensive study since it moved from being a 'respectable science' of the 1820s, to a 'crank science' by the mid-19th century. cf. David de Giustino (1975) 'Conquest of Mind: Phrenology and Victorian Social Thought'. Croom Helm, for one such study.

88. George Rosen (1946) 'The Philosophy of Ideology and the emergence of modern medicine in France'.
Bull. Hist. Med. 20(2) July p.328-39.

89. I. Waddington (1973) 'The Role of the Hospital in the Development of Modern Medicine: a sociological analysis'.
Sociology 7 p.211.

90. George Rosen (1946) op.cit. p.333.

91. Op.cit. p.338.

92. R. M. Jones (1973) op.cit. p.40-65, 177-204.
The term 'medical mecca' is quoted by Jones in his 1973 p.41 n6 referring to R. H. Shryock (1960) 'Medicine and Society in America, 1600-1800' N.Y. University Press, p.127. Jones calculates that nearly 700 American students/doctors spent 1-2 years in Paris between 1820-61. These students formed a generational linkage between clinical pathophysiological medicine of Paris and their own country's developing system

of medical care in this style of practice. Although it was concentrated in the urban centres of the N.E. and East Coast states.
In the English scene the Report of the Select Committee on Anatomy (568) p.7, stated that in 1828 200 English anatomy students had been to Paris to study. cf. I. Waddington (1973) op.cit. p.221 n47.

93. E. H. Ackerknecht (1967) op.cit. p.15.

94. I. Waddington (1973) op.cit. p.213.

95. J. R. Ravetz (1973) op.cit. p.93.
In his chapter 3 'Science as Craftsman's Work' (p.75-208) Ravetz has an interesting section on the role and function of 'Tools' (p.88-94) in which he elucidates their following characteristics.

1. They are the means by which the objects of investigation are created and shaped.
2. There are 4 kinds
   (a) physical tools e.g. equipment or 'hardware',
   (b) intellectual tools, e.g. statistics and mathematics,

   which vary in complexity, sophistication and have their own particular 'pitfalls'.
   (c) A corpus of standard information about the objects of inquiry, e.g. text books,
   (d) Specialized language systems.
3. They are auxiliary to the field of investigation but do decisively influence the direction of research. New tools, or more refined tools, help produce new fields of information or redirect established ones into more fruitful areas (e.g. use of lasers in plate tectonic theory).
4. Increasing complexity of knowledge and sophistication of tools can lead to natural division of labour between tool users and tool providers. A tool-providing speciality, like statistics, can be used in a whole range of disciplines. Their relationship is asymmetric on the basis of whether the field using the tools is one which deals with the more general and abstract properties of matter, and hence can provide tools for these disciplines dealing with more particular aspects of reality. For example, physics and chemistry provide analytical and statistical tools for physiology and pathology which itself provides basic knowledge for medical practice in diagnosis, prognosis and therapy.

96. F. H. Garrison (1917) op.cit. p.417-18.

97. e.g. Athanarius Kurcher (1602-80) in 1658.
Robert Hooke (1635-1703) in 1665.
Jan Swammerdam (1637-80) between 1658-67.
Anthony van Leenwenhoek (1632-1723) between 1674-83.
Marcello Malpiglii (1628-94) between 1665-73.
Fancesso Redi (1626-94).

98. a O. Temkin (1946) 'Materialism in French and German Physiology of the early nineteenth century'.
Bull Hist. Med. 20(2) p.322-27.
b E. Mendelsohn (1965) 'Physical models and physiological concepts: explanation in nineteenth century biology'.
Brit. Jour. of Science 2(7) p.201-19.
c David H. Galaty (1974) 'The Philosophical basis of mid-nineteenth century German reductionism'.
J. Hist. Med. 29 p.295-316.

99. a Auscultation is the method of discovering diseases of the lung by listening for the sounds arising from the external physical examinations of internal conditions.
b Percussion is the act of striking the surface of the patient's lung cavity (front or back) and determining, by the sound given off, the condition of the organs subjacent.

100. a R. M. Jones (1973) op.cit.
b E. H. Ackerknecht (1950) 'Elisha Bartlett and the philosophy of the Paris Clinical School'.
Bull Hist. Med. 24 p.43-60.
c H. Bloch, M.D. (1969) 'Pierre Charles Alexandre Louis' influence on American Medicine'.
N.Y. State Jour. Med. 69 p.3056-59.
d Dale C. Smith (June 1979) 'The emergence of organized clinical instruction in the nineteenth century American cities of Boston, New York and Philadelphia'.
Unpublished PhD manuscript. University of Minnesota, Faculty of the Graduate School.

101. June Goodfield-Toulmin (1969) 'Some Aspects of English Physiology 1780-1840'.
Jour. Hist. Biology 2(2) p.283-320.

102. ibid. p.307.

103. W. G. Rothstein (1972) op.cit. p.177.

104. O. W. Holmes (1860) 'Currents and Counter Currents' in his (1891) 'Medical Essays 1842-1882' by Houghton Mifflin p.203 his emphasis.

105. a William Coleman (1971) 'Biology in the Nineteenth Century: problems of form, function and transformation'. John Wiley & Sons Inc.
b W. G. Rothstein (1972) op.cit. ch. 13 'The beginning of scientific medicine: surgery', p.249-60.
c O. H. Wangensteen and S. D. Wangensteen (1978) 'The Rise of Surgery: from Empiric Craft to Scientific Discipline'.
University of Minnesota Press, ch. 20.
d A. J. Youngson (1979) 'The Scientific Revolution in Victorian Medicine'. Croom Helm.
According to Youngson surgical anaesthesia employing ether was successfully used in 1846, 16 Oct., by William Morton (a dentist)

and Horace Wells (his partner) to enable the surgeon, John Collins Warren (1778-1856), to remove a neck tumour from a 20 year old man.
The first use of chloroform anaesthesia was achieved by James Young Simpson, Professor of Midwifery at Edinburgh University on 15 Nov. 1847.
From about 1865 into the 1880s Joseph Lister, using Pasteur's insights on fermentation and putrefaction, developed an antiseptic system of surgery which took 15 years to be established and accepted.
But none of these innovations were accepted willingly and without objection by practising physicians who besides a kind of natural conservatism, had few links with research institutes or university medical faculties and were wary of 'scientific knowledge' which produced little in the way of effective, practical therapies.

106. Even today, despite modern 'wonder drugs' the iatrogenic costs have been high. At the GP level, the bulk of patients' ailments are for aches, pains, depressions, anxieties, headaches, colds, 'flu etc. which are not amenable to high-tech solution. Yet high-tech consultancy attracts a disproportionate supply of plant, personnel, technology and salaries. Fortunately (?), the Western world's monetary crisis has brought cut-backs which have begun to force a re-examination of medical care priorities and financing, with preventive medicine receiving a new intellectual overhaul.

107. W. G. Rothstein (1972) op.cit. p.187.

108. Op.cit. p.186.

109. Op.cit. p.191.

110. E.g. comparison of the Board of Health Treatment Committee statistics for metropolitan London, with those of the London Homeopathic Hospital, in the case of the 1854/55 Cholera Epidemic certainly show that to be treated by a homeopathic doctor was a decided advantage as far as surviving cholera, or cholera therapy, was concerned, compared to being treated by regular physicians employing regular therapies.

111. Dr. W. Hooker seems to have made something of a hobby of submitting such essays. Prior to this one submitted to the Massachusetts Medical Society, for which he won $100, he had submitted two other prize winning essays to the Rhode Island Medical Society of New York entitled 'Lessons from the History of Medical Delusions' (1850) and 'Homeopathy: an examination of its doctrine and evidences' (1857).

112. W. Hooker (1853) 'Rational Therapeutics . . . .' John Wilson and Son, p.3

113. Op.cit. p.7.

114. Op.cit. p.12.

115. Op.cit. p.15.

116. Op.cit. p.20.

117. Op.cit. p.25.

118. Op.cit. p.28-37.

119. Op.cit. p.38-39.

120. Op.cit. p.39.

121. Op.cit. p.43.

122. idem.

123. Op.cit. p.47.

124. Op.cit. p.49.

125. Op.cit. p.50.

126. Op.cit. p.51.

127. Op.cit. p.57.

128. E. H. Ackerknecht (1959) op.cit. p.50.

129. David Galaty (1974) op.cit.

130. N. D. Jewson (1976) op.cit. p.230.

131. Op.cit. p.231.

132. W. Bulloch (1938) 'The History of Bacteriology'. O.U.P., p.8-13.

133. Op.cit. p.20-29.

134. Op.cit. p.32-36.

135. A microscopic fungus now called Botrytis Bassiana.

136. Peter Baldry (1976) 'The Battle Against Bacteria: a fresh look'. C.U.P., p.27-32.

137. Op.cit. p.17-22. He published works on fermentation in 1857; the diseases of wine in 1863 and micro organisims in beer in 1871. His work on fermentation provided some support for those who held to a non-animate, fermentive, or chemical theory of contagion.

138 a Op.cit. p.22-24.
b Lois N. Magner (1974) 'A History of the Life Sciences'. Marcel Dekker Inc., p.243-51.

139. P. Bauldry (1976) op.cit. p.25.

140. W. Bulloch (1938) op.cit. p.62-63. It seems that depending upon whether the person favoured the 'contagion animatum' or 'miasmatic' explanation, the concept of Zymotes could be particulate and organic (like yeast and fungi) or chemical/ noxious gases.

141. Bulloch (1938) op.cit. p.7.

142. It also went under the name of the Effluvia, or Pythogenic theory of disease, referring to decaying matter and filth respectively.

143. Anthony S. Wohl (1983) 'Endangered Lives: public health in Victorian Britain'. J. M. Dent & Sons Ltd., p.87.

144. C. F. Brockington (1966 2nd edition) 'A Short History of Public Health'. J. A. Churchill Ltd. Ch. 5 'The birth of the Sanitary Ideal' 1840-1900 p.34-51, for a summary of sanitary reform until the 1870s, which saw the passage of the Public Health Act in 1848 and creation of the General Board of Health. Edwin Chadwick (1800-1890), a self-taught sanitary engineer and supporter of miasmatic theory, deeply influenced the Board and its views of disease causation, until 1855. This was when the clinical pathologist John Simon (1816-1904) was appointed as medical officer responsible to central government, and then the Privy Council, until 1871. This indicated a shift in favour of the contagionist theory and the advancement of 'the practice of public health from a simple exercise in engineering to a scientific discipline in epidemiology' (cf. Brockington p.45).

145. A. S. Wohl (1983) op.cit. p.88.

146. Bulloch (1938) op.cit. p.164-65.

147. S. Hughes (1977) 'The Virus: a history of a concept'. Heinemann, see ch. 3 'The infectious agent: exceptions to the conventional view', p.29-41.

148. Microtomy is the technique of making very thin sections for microscopic study. The tool used being termed a microtome. It was introduced by Wilhelm His in 1866 and was perfected about 1875.

149. Bulloch (1938) op.cit. p.213-17.

150. Op.cit. p.214. Carl Weigert (1845-1904) was not only famous for his staining of bacteria in 1871, but also his study in the pathological anatomy of smallpox (1874-75), Bright's disease (1879) and differential staining of the nervous system (1882).

151. a Peter Baldry (1976) op.cit. ch. 3 'The Enemy Named' p.27-32.
b Lois N. Magner (1979) op.cit. p.265-67.

152. Bulloch (1938) op.cit. p.214-15.

153. Op.cit. p.217-18.

154. a Op.cit. p.218 regarding Loeffler.
b F. H. Garrison (1917) op.cit. p.492 regarding Leibig's meat extract.

155. Bulloch (1938) op.cit. p.219. Edwin Theodor Alfrecht Klebs (1834-1913). German pathologist and pioneer bacteriologist.

156. Op.cit. p.220. Joseph Schroeter (1835-94) a mycologist and bacteriologist who worked with Ferdinand Julius Cohen (1828-98) in Breslau.

157. Op.cit. p.221-22.

158. In 1847 he co-founded the 'Archives for Pathological Anatomy' with Benno Reinhardt (1819-52) and in 1855 he published his paper on 'Cellular Pathology' in that journal.

159. L. N. Magner (1979) op.cit. p.170.

160. a Op.cit. p.171-72.
b and S. Bradbury (1967) 'The evolution of the microscope'. Pergamon Press p.229-34.

161. a S. Bradbury (1967) op.cit. p.257.
b However, L. N. Magner (1979) op.cit. p.265 states that it was a Zeiss oil immersion microscope Koch used in his 1872-76 studies of anthrax bocillus. According to Bradbury (1967) ibid. that just was not possible until 1878/9, after his anthrax research was completed.

162. W. G. Rothstein (1972) op.cit. p.263.

163. L. N. Magner (1979) op.cit. p.265, quoting a reminiscence of Cohen. Also quoted in H. Lechevalier and M. Solotorovsky (1974) 'Three Centuries of Microbiology'. Dover, p.69.

164. Frederic P. Gorham 'The history of bacteriology and its contribution to public health work', p.71, in M. P. Ravenel ed. (1970) 'A Half Century of Public Health'. Arno Press, p.66-93.

165. W. G. Rothstein (1972) op.cit. p.264. This is evocative of T. S. Kuhn's notion of 'normal science'; see Kuhn (1970 2nd ed.) ch. II-IV, p.10-42.

166. For example, lack of an experimental animal for the study of typhoid fever and cholera.

167. L. N. Magner (1979) op.cit. p.267.

168. idem. quoting Lechevalier and Solotorovsky (1974) op.cit. p.79. My emphasis.

169. a W. G. Rothstein (1972) op.cit. p.265;
b P. A. Richmond (1976) 'American attitudes towards the Germ Theory of Disease (1860-1880)' in G. H. Brieger ed. (1976) 'Theory and Practice in American Medicine'. Science History Pubs., p.58-84.
c R. H. Shryock (1948) op.cit. ch. 14 'The triumphs of modern medicine 1870-1900'.

170. S. S. Hughes (1977) op.cit. p.11-12. My emphasis.

171. R. C. Maulitz (1979) 'Physician versus Bacteriologist: the Ideology of Science in Clinical Medicine', p.92, in M. J. Vogel and C. E. Rosenberg (1979) op.cit. p.91-107.

172. a A reasonable summary of each of these bacteriologists' discoveries can be found in L. N. Magner (1979) op.cit. p.272-280, and P. Baldry (1976) op.cit. ch. 4-12.
b A populist 'millennial' history of the development of bacteriology can be seen in the hagiographical work of Paul de Kruif of 1927 entitled 'Microbe Hunters'. Jonathan Cape. Life and Letters Series (1930 edition consulted).

173. a W. G. Rothstein (1972) op.cit. p.275;
b F. H. Garrison (1917) op.cit. p.618.

174. W. G. Rothstein (1972) op.cit. p.277.

175. S. S. Hughes (1977) op.cit. p.21.

176. R. Kohler (1971) 'The Background to Eduard Buchner's discovery of cell-free fermentation'. J. Hist. Biol. 4 p.35-61.

177. S. S. Hughes (1977) op.cit. p.24.

178. a F. Suppes (1979) 'The Structure of Scientific Theories' 2nd Edition. University of Illinois Press.
b A. F. Chalmers (1978) 'What is this thing called Science?' Open University Press.
c Harold I. Brown (1979) 'Perception, Theory and Commitment: the new philosophy of Science'. University of Chicago Press (Phoenix Ed.)
These philosophical books will provide a good presentation and review of the recent historical and philosophical critique of positivist history and philosophy of science.

179. Caroline Whitbeck (1977) 'Causation in Medicine: the disease entity model'. Phil. of Science 44(4) p.622.

180. Op.cit. p.623.

181. idem.

182. The disease entity theory has often been understood as rather analogous to a secularized version of demon possession explanations for sickness.

183. C. Whitbeck (1977) op.cit. p.629-32.

184. a L. N. Magner (1979) op.cit. p.271.
b P. Baldry (1976) op.cit. p.31.
c S. S. Hughes (1977) op.cit. p.12-13.

185. S. S. Hughes (1977) p.13-14.

186. Op.cit. p.14-15.

187. L. N. Magner (1979) op.cit. p.271.

188. a I. Lakatos (1970) op.cit. p.139
b I. Lakatos (1976) 'Proofs and Refutation'. C.U.P., p.20-22, 83-87, 93-95, 101-102.

189. a P. Baldry (1976) op.cit. p.31-32.
b L. N. Magner (1979) op.cit. p.272.

190. L. N. Magner (1979) op.cit.

191. P. A. Richmond (1976) op.cit. p.81.

192. W. G. Rothstein (1972) op.cit. p.265.

193. Op.cit. p.266.

194. Op.cit. p.267, also see P. A. Richmond (1954) 'Some variant theories in opposition to the Germ Theory of Disease'. Jour. Hist. Med. 9, p.290-302.

195. The range of responses to homeopathy will be discussed in more systematic terms in ch. 6 of this work.

196. W. G. Rothstein (1972) op.cit. p.279.

197. Vaccination for Cow-pox, surgery for septicaemia/pyaemia, chronic tonsillitis, mercury or potassium iodide for syphilis, diet for beri-beri and scurvy.

198. W. Osler (1898) 'Principles & Practice of Medicine'. Pentland p.1-348. Treatment in his other sections were reduceable to surgery, pain relief, nursing, diet, prophylaxis regarding secondary infection, ice packs, hydrotherapy, tonics and purgatives. The most intractable and virtually untreatable diseases being included in his section on 'Diseases of the Nervous System', p.901-1147. Here the most common treatments were diet, quiet

and regulated life, pain relief, massage, hydrotherapy, ice packs, counter-irritation, re-education/training in motor skills, nursing, bed rest, sometimes venesection, sometimes surgery, and of course, moral control by parents and nursing staff.

199. W. Osler (1932) 'Aequanimitas'. Blakiston's Son, p.254-55.

200. S. E. D. Short (1983) 'Physicians, Science and Status: issues in the professionalization of Anglo-American medicine in the nineteenth century'.
Med. History 27, p.51-68.

201. T. McKeown (1976) 'The Modern Rise of Population'. Academic Press.

202. W. Osler (1898 3rd ed.) op.cit. p.1-348.

203. W. G. Rothstein (1972) op.cit. p.61.

204. Col. Barraclough (1980) 'The development of Homeopathy in Great Britain and its present position within the NHS'. Homeopathic Trust, Annual Lecture.

205. a For a sociological analysis of the shift from 'person' to 'object' oriented medical cosmologies see:
N. D. Jewson (1976) op.cit. p.231-40.

b For a sociological analysis of the increasing scientification of medical craft see:
Judy Sadler (1978) op.cit. p.177-215.

REFERENCES TO CHAPTER 4

1. a Harris L. Coulter (1973) 'Divided Legacy: a history of the schism in medical thought' Vol. III 'Science and ethics in American Medicine - 1800-1914'. McGrath Pub. Co.
b M. Kaufman (1971) 'Homeopathy in America: the rise and fall of a medical heresy'. Johns Hopkins University Press.
c W. G. Rothstein (1972) 'American Physicians in the Nineteenth Century: from sects to science'. Johns Hopkins University Press.

2. Kaufman's and Rothstein's work on homeopathy will be critically reviewed in chapter 6. Harris L. Coulter presents an even more massively referenced work than either of these two, but unfortunately I think he allowed his excellent intentions to be seduced onto the side of the homeopaths and their stance towards the regulars. Not that this is morally wrong, since he makes out an excellent case in their support. However, it lacks self-critical awareness because in his attempt to 'minimise the passional content and concentrate on ideas' op.cit. Vol. 3 (xi) he falls prey to those very passions. What he does do very successfully is to describe the 'ideological warfare' between the regulars and the homeopaths such that one is left in no doubt as to the individual and corporate depths regular practitioners could go in the cause of professedly high ideals of conscience and morality in opposing homeopathy and stigmatizing homeopaths.

3. M. Kaufman (1976) 'American Medical Education: the formative years 1765-1910'. Greenwood Press, p.55-77.

4. H. L. Coulter (1973) op.cit. Vol. 3 p.5-6, 87-126; M. Kaufman (1971) op.cit. p.1-52; M. Kaufman (1976) op.cit. p.36-77; op.cit. W. G. Rothstein (1972) op.cit. p.26-38, 41-61, 125-151, 152-174, 212-229 for details of the development of these occupations. However, bear in mind that, generally speaking, education placed some Botanics, Eclectics and most Homeopaths on a relatively equal footing with the regular practitioners.

5. This periodization is taken from the establishment of Jamestown (Virginia) by the English settlers in 1607 to the formation of a national government and federal constitution in 1789. The British government attempted direct control in 1763; the Declaration of Independence was made in 1776 and a confederation of republics formed by 1783, prior to the national government being formed. Between 1789-1801 the new government was being organized and consolidated under the presidencies of George Washington (1789-97) and John Adams (1797-1801).

6. W. G. Rothstein (1972) op.cit. p.34.

7. idem.

8. idem.

9. Op.cit. p.36. By 'empirics' Rothstein means the Indian/herb doctors and uneducated botanics. Even after the Civil War (1861-65) this could still be said of 'empirics' and regulars, as well as the homeopaths, remaining botanics, Thomsonians, eclectics and their various cessesionist splinter groups.

10. Op.cit. p.26 and p.37-38.

11. Op.cit. p.63-64.

12. Op.cit. p.73.

13. idem.

14. idem.

15. M. Kaufman (1976) op.cit. p.36-56.

16. W. G. Rothstein op.cit. p.80.

17. This could be interpreted as a presentist critical evaluation of the situation in 19th century American society. However, it is justifiable historically, as well as ethically. For empirical evidence to base this judgment upon see: Alan Doig (1984) 'Corruption and Misconduct in Contemporary British Politics'. Penguin Books, especially ch. 2 'The Historical Perspective', p.36-67, which does consider the American situation too. In discussing corruption and misconduct Doig says ''Corruption is bribery and bribery is corruption. Bribery is a transactional offence that concerns the use or proposed use of inducements or rewards to influence actions or decisions . . . to ensure an outcome specifically favourable to the donor'' (p.25). This rather legal definition has a moral analogue in terms of the unconscious, unverbalized agreement between a donor and recipient in a situation where both benefit by the tacit agreement to give and receive 'inducement'.

18. W. G. Rothstein (1972) op.cit. p.81.

19. a William R. Johnson (1974) 'Education and Professional life styles: Law and Medicine in the Nineteenth Century'. Hist. Ed. Q. Vol. 14, p.185-207.
    b Wilhelm Moll (1968) 'History of American Medical Education'. Brit. J. Med. Educ. 2, p.173-181.
    c W. G. Rothstein (1972) op.cit. ch. 5, p.85-100.
    d Frederick C. Waite (1946) 'American Sectarian Medical Colleges before the Civil War'. Bull. Hist. Med. Vol. 19 (2) Feb., p.148-66.

20. W. G. Rothstein (1972) op.cit. p.89.

21. For a good historical introduction to the philosophy, practices and personalities of the Paris School of Clinical-Hospital Medicine, see:
E. H. Ackerknecht (1967) 'The Paris School of Clinical Medicine'. Johns Hopkins Press.
For its influence upon American Clinical Medicine see:
a E. H. Ackerknecht (1950) 'Elisha Bartlett and the philosophy of the Paris Clinical School'.
Bull Hist. Med. 24, p.43-60.
b H. Block, M.D. (1969) 'Pierre Charles Alexandre Louis' influence on American Medicine'.
N.Y. State J. Med. 69, p.3056-59.
c R. M. Jones (1970) 'American Doctors in Paris, 1820-1861: a statistical profile'.
J. Hist. Med. 25, p.143-57.
d R. M. Jones (1973) 'American Doctors and the Parisian Medical World, 1830-1840'.
Bull Hist. Med. 47, p.40-65, 177-204.
e D. C. Smith (June 1979) 'The Emergence of Organized Clinical instruction in the nineteenth century American cities of Boston, New York and Philadelphia'.
Unpublished Ph.D. thesis submitted to the Faculty of the Graduate School of the University of Minnesota.
f W. R. Steiner (1939) 'Some distinguished American students of Pierre-Charles-Alexander Louis of Paris'.
Bull Hist. Med. 7, p.783-93.
g W. R. Steiner (1960) 'Dr. Pierre-Charles-Alexander Louis, a distinguished Parisian teacher of American medical students'.
Ann. Med. His. 3(2), p.451-60.
For discussion of its influence upon the development of epidemiology see:
D. E. Lilienfeld and A. M. Lilienfeld (1980) 'The French influence on the development of Epidemiology',
in Abraham M. Lilienfeld M.D. (1980) 'Times, Places and Persons: Aspects of the History of Epidemiology'. Johns Hopkins University Press, p.28-38, with discussions of the paper by Caroline Hannaway, p.39-42.

22. W. G. Rothstein (1972) op.cit. p.101.

23. idem.

24. M. Kaufman (1976) op.cit. p.57-77.

25. M. Kaufman (1971) op.cit. p.1-23.

26. M. Kaufman (1971) op.cit. p.23.

27. idem.

28. H. L. Coulter (1972) Vol. 3, Chapter 3, p.140-219

29. H. L. Coulter (1972) Vol. 3, op.cit., p.99-100.

30. H. L. Coulter (1972) op.cit. p.96-97, quoting the Boston Medical and Surgical Journal, Vol. 28 (1843) p.323-24.

31. A position which, by itself, was to prove quite ineffective until the last two to three decades of the 19th century, when the 'scientification' of medicine was effective as a means of standardizing medical knowledge and practice. This process also intersected with the emergence of a national elementary and higher education system, the increasing co-ordination of national medical associations for general practitioners and hospital specialists (represented in the A.M.A.), examining and licensing boards, and medical colleges (American Medical College Association founded 1876) in the area of accreditization over education, teaching and standards of practice. In short, a kind of 'medical cartel' was formed between national organizations representing the dominant institutions of regular medicine and encouraged mainly via the A.M.A. and its representatives. cf. M. Kaufman (1976) op.cit. passim.

32. M. Kaufman (1967) op.cit. p.71.

33. Op.cit. p.70-71.

34. Detwiller was the second recorded homeopath in the U.S. He was a Swiss physician who emigrated to Pennsylvania in 1817. Through his own reading and correspondence he was converted to homeopathy in the late 1820s. He was joined by Hering (1800-80) in 1833. The latter man became known as the Father of American Homeopathy.

35. F. C. Waite (1946) 'American Sectarian Medical Colleges before the Civil War'.
Bull Hist. Med. 19(2) Feb. p.162-163.

36. W. G. Rothstein (1972) op.cit. p.160.

37. W. G. Rothstein (1972) op.cit. p.58-59.
M. Kaufman (1978) op.cit. p.25-30.
By the term 'success' can be meant the positive evaluation of homeopathy compared to heroic practice in regard to the number of patients who responded positively to specific therapy and either improved from their original set of disease symptoms, or completely from the original illness. Negatively, it can refer to the number of patients who survived the therapeutic ministrations of homeopathic or heroic practitioners.
Statistically, in terms of crude mortality figures and percentage recoveries, homeopaths consistently did better than their heroic counterparts. Publication of these statistical tables was a definite part of the ideological battle between regulars and homeopaths for the hearts, minds and money of the public.

38. H. L. Coulter (1973) Vol. 3, op.cit. p.102-104.

39. W. G. Rothstein (1972) op.cit. p.163, quoting from the Homeopathic Examiner, in reference to:
[John F. Gray] 'Duty of Physicians of either school to study both systems'.
Hom. Examiner 1 (1840) p.35.
J. C. Peters 'To John F. Gray'.
Hom. Examiner 3 (1843) p.370.
See his n.31 on p.163.

40. H. L. Coulter (1973) Vol. 3 op.cit. p.103.

41. W. G. Rothstein (1972) op.cit. p.165.
H. L. Coulter (1973) Vol. 3 op.cit. p.140-219.

42. W. G. Rothstein (1972) op.cit. p.166.

43. As W. G. Rothstein (1972) idem incorrectly asserts I believe.

44. W. G. Rothstein (1972) op.cit. p.245 and note 40. An article in the 1899 Transactions of the American Institute of Homeopathy (AIH) by J. H. McClelland pointed out that the 'curantur' spelling made the 'similia' a law of nature, whereas the curentur version made it a method of treating disease. The A.I.H. changed its motto to the methodological version of the homeopathic 'similia'.

45. W. G. Rothstein (1972) op.cit. p.169.

46. A. Giddens (1979) 'Central Problems in Social Theory'. Macmillan, p.219.

47. The psychoanalytic arguments about psychic anxiety and its connection with anti-quack ideology as a form of rationalized anxiety projection is not an issue to be exploited in any depth in this work, although it will be employed where useful.

48. H. L. Coulter (1973) Vol. 3 op.cit. p.156, quoting L. M. Lawson (1846) "A Review of 'Homeopathy, Allopathy and Young Physic'." Scrugham and Dunlop, p.4-5.

49. A secularized reading of anthropological discussions of pollution and taboo, pollution and paradigms is used here. It is merely referred to here without comment but for further development see chapter 6. For a general introduction see:-
Mary Douglas (1966) 'Purity and Danger: An analysis of the concept of pollution and taboo'. R.K.P.
R. G. Willis (1972) 'Pollution and Paradigms'
in D. Landy (ed) (1977) 'Culture, Disease and Healing', Macmillan, p.278-85.

50. H. L. Coulter (1973) Vol. 3 op.cit. p.157. My emphasis. Coulter is quoting from the 'Transactions of the New Hampshire Medical Society (1856)' p.39-40.

51. Op.cit. p.155-56, quoting from:
Worthington Hooker (1851) 'Homeopathy: an examination of its Doctrines and Evidences'. Charles Scribner, p.145.

52. H. L. Coulter (1973) Vol. 3 op.cit. Chapter III p.140-236.

53. Mary Douglas (1966) op.cit. p.36.

54. I only indicate the matter here. It will be taken up in Chapter 6 in greater detail.

55. The Thomsonians had had annual conventions from 1832-38, but internal division over the future of the movement as a 'lay' or 'professional' organization caused Alva Curtis (1797-1880) (editor of the 'Thomsonian Recorder') to split with Samuel Thomson and form the 'Independent Thomsonian Botanic Society'. For details see:
A. Berman (1951) 'The Thomsonian Movement and its relations to American Pharmacy and Medicine'.
Bull Hist. Med. 25(5) Sept.-Oct. p.405-28, 519-38, especially p.418-21, on national conventions and p.424-28 on the Thomson-Curtis conflict.

56. H. L. Coulter (1973) Vol. 3 op.cit. p.125, quoting from the 'Proceedings of the American Institute of Homeopathy' Vol. 1 (1846) p.3

57. Op.cit. p.41 note (b).

58. Op.cit. p.125, quoting the 'Proceedings' of the A.I.H. Vol. 1 (1846) p.5

59. Op.cit. p.125.

60. F. W. Waite (1946) op.cit. p.163.

61. H. L. Coulter (1973) Vol. 3 op.cit. p.179.

62. M. Kaufman (1976) op.cit. p.78-92.

63. M. Kaufman (1976) op.cit. p.80-81.

64. Op.cit. p.82-86.

65. Op.cit. p.84.

66. W. G. Rothstein (1972) op.cit. p.170.

67. Joseph Kett (1968) 'The Formation of the American Medical Profession'. Yale University Press, p.165.
There was an initial lack of enthusiasm for such a convention due to previous failed attempts, but also because the Philadelphia University and medical college saw the efforts of

the N.Y. Medical Society and school as a way of advertising and supporting their own schools against the Philadelphia ones. This view changed when Martyn Paine of the N.Y. University School of Medicine criticised N. S. Davis and the whole idea of the convention as an attempt to produce an elite group of practitioners and destroy the medical schools at the same time.
cf. M. Paine (1846).'A defence of the medical profession of the United States'. N.Y., referred to by D. C. Smith (June 1979) 'The emergence of organized clinical institutions in the Nineteenth Century American cities of Boston, New York and Philadelphia'.
Unpub. Ph.D. Graduate School of University of Minnesota, p.230-233.

67. Joseph Kett (1968) op.cit. p.165.

68. a H. L. Coulter (1973) Vol. 3, p.183.
b D. E. Konold (1962) 'A History of American Medical Ethics 1847-1912', pub. by The State Historical Society of Wisconsin for the Dept. of History, University of Wisconsin. Madison, p.8-9.
c J. Kett (1968) op.cit. p.170-71
d M. S. Jacobs (1946) 'Philadelphia 1846: men and events that influenced the development of organized medicine'. Bull Hist. Med. 20(2) p.250-56.
e M. Kaufman (1976) op.cit. p.87-88.

69. J. Kett (1968) op.cit. p.170.

70. M. Kaufman (1976) op.cit. p.90.

71. J. Kett (1968) op.cit. p.171. The emphasis on French clinical education being explained by the fact that many of the A.M.A. Education Committee had been trained in Paris;
cf. M. Kaufman (1976) op.cit. p.101.

72. H. L. Coulter (1973) Vol. 3, p.185-87.

73. J. Kett (1968) op.cit. p.173.
M. Kaufman (1976) op.cit. p.93-108.

74. J. Kett (1968) op.cit. p.177.

75. a idem.
b M. Kaufman (1976) op.cit. p.109-126 extends Kett's periodization to 1890 at least.
Kaufman's description of further deterioration of the condition of medical education between 1860-90 does not exclude isolated advances. Kett's study ends just before the beginning of the Civil War in 1861, and so explains his limited periodization as to the ineffectiveness of voluntary medical associations, like the A.M.A.

76. M. S. Jacobs (1946) op.cit. p.251, quoting from the report of the Address of the Medical Convention of May 1847.

77. I deliberately chose the term 'exorcism' rather than one of its synonyms (e.g. ostracism), because of its clear connotation of expelling a 'wicked', 'unclean thing', a 'deadly miasm' - a process of purifying what had become polluted by an alien presence. cf. the quotation for ref. (50) for an example of the kind of rhetoric produced by the desire for professional purity.

78. Percival had originally formulated his code to resolve the professional confusion arising from a dispute between the house-staff of the Manchester Infirmary, in 1789.

79. In terms of general sociological theory the A.M.A. Code of Ethics is an instantiation of a structural feature of any social system (e.g. occupational group): that of a system of legitimation and hence of normative regulation. The latter term in no way assumes normative consensus on the part of the collectivity formulating the norms.
cf. A. Giddens (1979) 'Central Problems in Social Theory'. Macmillan, p.81-88, 97, 101-103.
In more specific terms, the code and consultation clause set out the criteria for inclusion with and exclusion from the 'proper' medical profession. It also, implicitly, sets out the criteria of transformation from homeopathic to regular belief and practice. Its implementation is part of the ideological warfare and stigmatization employed by the regulars to delegitimate and stereotype the homeopaths.
cf. E. M-Schur (1980) 'The Politics of Deviance: stigma contests and the use of power'. Prentice Hall Inc. for a further sociological description of this process.

80. W. G. Rothstein (1972) op.cit. p.171-72.

81. Op.cit. p.171, quoting Austin Flint 'Medical Ethics and Etiquette'.
N.Y. Med. Jour. Vol. 37 (1888) p.371-72.

82. W. G. Rothstein (1972) op.cit. p.173.

83. M. Kaufman (1971) op.cit. p.49.

84. Op.cit. p.61.

85. J. Kett (1968) op.cit. p.161, quoting Worthington Hooker (1852) 'The Present Attitude and Tendencies of the Medical Profession'.
New Haven p.15.

86. J. Kett (1968) op.cit. p.163.

87. D. E. Konold (1962) op.cit. p.12, quoting from the president of the A.M.A., George B. Wood, in 'Transactions of the American Medical Association', Vol. 9 (1856) p.61.

88. M. Douglas (1966) op.cit. Chapter 1-2, 6-8 inclusive.

89. ''During the course of the nineteenth century about seventy-five anti-homeopathic books and pamphlets were published in the United States and Great Britain. Most medical texts contained one or two slight(ing) references to this school, and there were any number of short articles and notes attacking homeopathy in the allopathic periodical literature. Such works were still appearing in the 1890s, and even in the twentieth century an official of the American Medical Association has devoted effort to refuting doctrines which by that time were almost 150 years old''. cf. H. L. Coulter (1973) Vol. 3 op.cit. p.159. The 20th century A.M.A. official was Morris Fishbein, one time A.M.A. president.

90. H. L. Coulter (1973) Vol. 3 op.cit. p.158.

91. J. Kett (1968) op.cit. p.158.

92. 'Dictionary of American Biography' (1929) (ed) A. Johnson Vol. 2 p.258. O.U.P. and Humphrey Millford (abbreviated to D.A.B.).

93. Miriam R. Small (1962) 'Oliver Wendell Holmes'. Twayne Pub. Inc. p.40; quoting from J. T. Morse Jr. (ed) (1896) 'The Life and Letters of Oliver Wendell Holmes' (Vol. 1). Houghton, Mifflin and Co., p.104.

94. Miriam R. Small (1962) ibid, quoting J. T. Morse Jr. (ed) (1896) op.cit. p.436.

95. Idem.

96. D.A.B. (1932) Vol. 9, p.171.

97. M. R. Small (1962) op.cit. p.48.

98. D.A.B. (1932) op.cit. Vol. 9 p.172. cf. 'Hugh Lenox Hodge' (1796-1873) D.A.B. (1932) op.cit. Vol. 9, p.49-100, and Charles Delucend Meigs (1792-1869) D.A.B. (1933) op.cit. Vol. 12, p.503-4.

99. This Society was ''a group of men who had attained positions of importance in many fields and who were more vigorous than the elaborate name would indicate''. cf. M. R. Small (1962) op.cit. p.50.

100. Oliver Wendell Holmes (1842) 'Homeopathy and its kindred delusions' to be found in his (1891) 'Medical Essays', Sampson Low, Marsden Searle and Rivington, London, pp.1-102.

101. O. W. Holmes (1842) op.cit. p.3.

102. Op.cit. p.2. He deals with these four topics on pp.1-38 in 'Medical Essays', then turns to homeopathy on pp.38-102.

103. Op.cit. p.39.

104. idem.

105. Op.cit. p.40.

106. ibid.

107. cf. op.cit. pp.60, 73 and 77 for Louis and Andral; pp.53, 58, 61, 64, 77 and 81 for others Holmes mentions.

108. Op.cit. p.41.

109. a H. M. Collins and T. J. Pinch 'The Construction of the Paranormal: nothing unscientific is happening' in R. Wallis (ed) (1979) 'On the Margins of Science: the social construction of rejected knowledge'.
University of Keele Sociological Review Monograph 27, p.237-70.
The differentiation, made by Collins and Pinch, of contests of debate between mainstream and marginal-unorthodox 'science', into constituative (i.e. professional and expert) and contingent (non-professional, lay) forums is useful but I would want to emphasize the permeability factor in such debates, especially with an applied science occupation like medicine.

b Edwin M. Schur (1980) 'The Politics of Deviance: stigma contests and the uses of power'. Prentice-Hall Inc.
A stigma contest is a struggle between individuals and/or groups who have competing social definitions of themselves and their opponents and their outcomes indicate the relative social power of the individuals and/or groups involved (p.7). The outcome is the 'deviantizing' of one of the individuals/groups. The process whereby such an outcome is achieved is both the medium and product of prior power configurations (p.7).

110. On p.46 of his essay he gives a chart showing the relation of dilutions to potencies and their calculation. On p.53 he makes the mistake of changing his units of dilution from drops to pints. He miscalculates because he assumes for each dilution you need 100 times more of the total unit of the medium from the previous dilution than is necessary. Whereas all you need is one drop from the previous solution to be added to 100 drops of the next unit of medium (or 10 if using a decimal scale rather than centecimal). So, for the fourth dilution it would have needed only 400 drops of medium to reach it (not 1000 gallons as he states). He becomes ridiculous, therefore, when he claims that the 9th dilution would need 10 billion gallons, i.e. the size of Lake Agnano, 2 miles in

circumference. In fact to reach the 9th dilution only 400 drops/units are needed to reach it. Because of this simple misunderstanding of how homeopathic medicines are prepared and his own ideologically prior dispositions he descends to poking fun. But his ridicule is actually had at the expense of his own mistaken understanding. This kind of error is repeated by other authors discussing dilutions (e.g. Lancet 1850, Vol. 2 Sat. Sept. 7, p.300-302) and remains uncorrected due to the primary intention to demonstrate homeopathy's absurdity whatever the homeopaths say by way of explanation or defence.

111. The two prefaces to his 'Medical Essays' (1891) op.cit. clearly have such a sense about them.
''The flattering assumptions that his readers were really educated persons and could be approached as such, must be counted high among the fruits of his non-professional education'' (D.A.B. (1932) Vol. 9 op.cit. p.170). Considered together with his sound anatomical knowledge from the Paris School he ''possessed uncommon gifts as a lecturer'' (op.cit. p.172) and became a very popular writer and lecturer, far beyond the confines of the Medical School.

112. Op.cit. p.100-02. My emphases, to pick out the stigmatizing rhetoric of Holmes' typical anti-quack, anti-homeopathic professional ideology.

113. O. W. Holmes (1891) 'Medical Essays' op.cit. Preface of 1861 p.ix-x.
The 'vis medicatrix naturae' (healing power of nature) was an emerging and eventually normal explanation of how and why homeopathy was successful during the second half of the century.
cf. W. G. Rothstein (1972) op.cit. p.166 and n.38.

114. O. W. Holmes (1891) op.cit. Preface to New Edition p.xiv.

115. O. W. Holmes (1842) op.cit. His first lecture on the Royal Cure, Weapon Ointment and Sympathetic Powder, Bishop Berkley's tar water, and Perkinism are simply a pre-amble to homeopathy at most and tar homeopathy with the same brush of 'quackery', at least. See especially his lecture on homeopathy pp.1-2, 49-50, 93-94, where he mentions the previous quackeries in association with homeopathy.

116. Op.cit. pp.41, 64-66, 76, 82, 98.

117. Op.cit. p.100-102.

118. H. L. Coulter (1973) Vol. 3 op.cit. p.195.

119. Cast in the role of the bearers of social disorder, destroyers of 'scientific' medicine, as culpable heretics rather than ignorant ones. This is a particularly intensive form of stigmatization based largely upon ad hominem arguments and ridicule.

120. M. Kaufman (1971) op.cit. p.70-76, 86-110.

121. a A. H. Okie (1842) 'Homeopathy: with particular reference to a lecture by O. W. Holmes, M.D.'. Otis Clapp, Boston.
b Charles Neidhard (1842) 'An Answer to the Homeopathic Delusions of Dr. Oliver Wendell Holmes'. J. Robson, Philadelphia.

122. C. Niedhard op.cit. p.4-5. My emphasis.

123. Op.cit. p.14.

124. Op.cit. p.24.

125. The truth or otherwise of these stories is not at issue here, but their role in the ideological conflict is.

126. cf. note 113 above.

127. a H. L. Coulter (1973) Vol. 3 op.cit. p.170-74 on 'Explanation of homeopathic cures' generally, p.173 on the 'vis medicatrix naturae' in particular.
b W. G. Rothstein (1972) op.cit. p.166.
c John H. Warner (1977-78) 'The Nature-Trusting Heresy: American physicians and the concept of the healing power of nature in the 1850s and 1860s'.
Perspectives on American History Vol. 11 p.291-324.

128. O. W. Holmes (1891) op.cit. preface of 1891 xv-xvi and W. G. Rothstein (1972) op.cit. p.178-79.

129. This was not achieved until the 1870s onwards when medical education reform received a fresh impetus from the establishing of the Association of American Medical Colleges and the beginning of the construction of the Johns Hopkins University and Medical School, both in 1876, which was the year of Koch's publication of his bacteriological research.
cf. M. Kaufman (1976) Chapters 8-11 inclusive.

130. H. L. Coulter (1973) Vol. 3 op.cit. p.202.

131. O. W. Holmes (1842) op.cit. p.1-39.

132. H. L. Coulter (1973) op.cit. p.158-59, 166, 176-79

133. a H. L. Coulter (1973) op.cit. p.216 quoting from 'An Ethical Symposium, Being a Series of Papers Concerning Medical Ethics and Etiquette from the Liberal Standpoint' 1883 G. P. Putnam's Sons, p.53.

134. H. L. Coulter (1973) op.cit. p.218.

135. With Worthington Hooker (1806-67) being a particularly hostile proponent of anti-homeopathic ideology during the 1850s and 1860s; cf. Coulter (1973) op.cit. pp.158-59, 165, 195-99.

136. a H. L. Coulter (1973) op.cit. Ch. 5 p.285-327.
b M. Kaufman (1971) p.140-146.

137. M. Kaufman (1971) p.142.

138. Op.cit. p.144.

139. Op.cit. p.148.

140. H. L. Coulter (1973) op.cit. Ch. 6 for the doctrinal, institutional, economic and psychological aspects of this split, i.e. p.328-401.

141. M. Kaufman (1971) op.cit. p.115-126.

142. H. L. Coulter (1973) op.cit. p.313, quoting from an anonymous author in the 'Medical Record' Vol. 21 1882, p.156.

143. a H. L. Coulter (1973) op.cit. p.313-14.
b M. Kaufman (1971) op.cit. p.126-36.
c W. G. Rothstein (1972) op.cit. p.301-305.

144. M. Kaufman (1971) op.cit. p.129.

145. Op.cit. p.130.

146. Op.cit. p.131.

147. M. Douglas (1963) op.cit.

148. W. G. Rothstein (1972) op.cit. p.278-79. The A.I.H. (the eclectic homeopaths) legitimated bacteriology as acceptable to homeopathy by interpreting Hahnemann as the forebear of bacteriology, p.278.

149. W. G. Rothstein (1972) op.cit. p.283-85.

150. a M. Kaufman (1976) op.cit. p.139,
b W. G. Rothstein (1972) op.cit. p.286.

151. a M. Kaufman (1976) op.cit. Ch. 8, p.127-42.
b W. G. Rothstein (1972) op.cit. Ch. 15, p.282-97.

152. W. G. Rothstein (1972) op.cit. p.293.

153. The merchant and philanthropist, Johns Hopkins (1795-1873), had made out a will in 1870 to the effect that the bulk of his fortune - after amply providing for relatives - of about

$8 million would be used for the good of mankind. He thus left $7 million to be used equally for the building and endowment of the Johns Hopkins University and Johns Hopkins Hospital. The remainder was for philanthropic work amongst disadvantaged young people and their dependants.
cf. 'Dictionary of American Biography' (1932) (ed) Durrins Malone, pub. Charles Scribner's Sons and Oxford Univ. Press, Vol. 9, p.213-14.

154. Amongst the foremost of the staff were Dr. William Henry Welch (1850-1934) as Professor of Pathology and Dr. William Osler (1849-1914) who was both Professor of Theory and Practice of Medicine and Physician-in-Chief of the Johns Hopkins Hospital. They made innovative use of laboratory work and bed-side teaching, respectively.
cf. (a) M. Kaufman (1976) op.cit. Ch. 9
(b) W. G. Rothstein (1972) op.cit. p.288-91, 293-94
(c) D.A.B. (1934) Vol. 14 op.cit. p.83-87 re 'Osler'
(d) D.A.B.(1936) Vol. 19 op.cit. p.621-24 re 'Welch'.

155. M. Kaufman (1971) op.cit. p.149.

156. W. G. Rothstein (1972) op.cit. p.290.

157. Formerly the American Medical Colleges Association 1876-82.

158. W. G. Rothstein (1972) op.cit. p.294-97.

159. H. L. Coulter (1973) op.cit. p.402-19.

160. a W. G. Rothstein (1972) op.cit. p.235;
b H. L. Coulter (1973) op.cit. p.293b, 334.

161. W. G. Rothstein (1972) op.cit. p.295.

162. Op.cit. p.296.

163. Op.cit. p.317-20.

164. Op.cit. p.319.

165. Op.cit. p.321 quoting 'Report of the Committee on Medical Ethics'.
J.A.M.A. Vol. 40 (p.1903) p.1379-81.

166. M. Kaufman (1971) p.156.

167. e.g. Dr. Richard C. Cabot, in 1905, publicly confessed the wrong attitude of the 'allopaths' to homeopaths; especially on their self-ascription of the label of 'regular', implying all non-conformists were 'irregular' or 'quacks'. He also admitted that the question which should have been asked regarding homeopathy was not 'Is it logical?' (as O. W. Holmes had done) but 'Does it work?' which the American homeopaths had been urging on their 'allopathic' brethren for over seventy-five years.

168. C. D. Leake (1975) 'An Historical Account of Pharmacology to the Twentieth Century'. Charles C. Thomas. Chapters 9 and 10 on Pharmacology in the 19th century, p.119-39, 140-169 respectively.

169. a E. W. Ackerknecht (1962) 'Aspects of the history of therapeutics'. Bull Hist. Med. 36(5) Sept.-Oct., p.389-419.
b W. G. Rothstein (1972) op.cit. p.185-186.

170. Abraham M. Lilienfeld (1982) 'Ceteris Parabus: the evolution of the clinical trial'. Bull Hist. Med. 56 p.1-18. p.18 provides a diagrammatic summary of his historical evidence and it clearly indicates that truly systematic, randomized clinical trials began in 1938. Even if the use of concurrent comparative statistical studies like the 1854/55 cholera epidemic in London are used as a base line of sophistication, then the results produced were limited in value because the treatment committee of the Board of Health decided they could only deal with relative proportions of collapse to death in order to test for severity of the cholera. Also they decided they had inadequate evidence to judge the question of the dosages of medications to recovery and morbidity (p.9).

171. e.g. Knowledge can be replaced in whole or part by new knowledge, or it can expand into previously unknown areas. Ignorance is always 'ignorance-for-the-time-being' but its functions in relation to the ideological relationships of competing groups and the way that historians perceive them is extremely important in its complications. Interesting as this issue could become, philosophically, we must suspend further discussion and return to the historical materials.

172. 'Collier's Encyclopaedia' (1974) Vol. 20, p.117-118. Macmillan Educational Corp.

173. A. Flexner (1910) 'Medical Education in the United States and Canada'. Boston.

174. i.e. Theobold Smith, Herman M. Biggs, Simon Flexner, William H. Welch, T. Mitchell Prudden, L. Emmett Holt and Christian A. Herter.

175. H. L. Coulter (1973) op.cit. p.463 n.200, quoting Allan Nevins (1940) 'John D. Rockefeller: the Heroic Age of American Enterprise'. Charles Scribner's Sons, Vol. 2, p.263.

176. D.A.B. (1931) A. Johnson and D. Malone (eds) Vol. 7, O.U.P./ Scribner's Sons, p.182-83.

177. H. L. Coulter (1973) op.cit. p.449-50, referring to:
'The General Education Board: An Account of its Activities 1902-1914' (1915) Gen. Education Board, p.168-70, and
'The General Education Board: Review and Final Report 1902-1964' (1964) p.34, 37.

178. H. L. Coulter (1973) op.cit. p.436.

179. G. E. Markowitz and D. K. Rosner (1973) 'Doctors in Crisis: a study of the use of medical education reform to establish modern professional elitism in medicine'.
Am. Quarterly 25 p.83-107.

180. S. E. D. Short (1983) 'Physicians, Science and Status: issues in the professionalization of Anglo-American medicine in the nineteenth century'.
Med. History 27 p.67.

181. Samuel Haber (1964) 'Efficiency and uplift: scientific management in the progressive era, 1890-1920'. University of Chicago Press.

182. a G. W. Corner (1964) 'A History of the Rockefeller Institute 1901-1953'. Rockefeller Institute Press.
b G. E. Markowitz and D. K. Rosner (1973) op.cit. p.98.
c W. O. Smith Snr. (1974) 'The development of American Medical Research and the influence of John D. Rockefeller. Pt. 1.
Jour. Oklahoma Med. Assoc. 67, p.146-55.

183. M. P. Ravenel (1970) 'A half-century of Public Health'.
Arno Press.

184. e.g. William Welch was a member of Johns Hopkins University-Hospital-Medical School complex and the Board of Scientific Advisers to the Rockefeller Institute, as well as being president of the A.M.A. in 1910, and the Baltimore and Maryland State Board of Health (1898-1922).
This is not indicated so as to imply anything of a conspiratorial nature about Flexnerization, or the triumph and pervasiveness of a specific ideology of science. However, it is to point out that ideologies don't 'float' in the air, they are held to and diffused by committed people seeking to extend their own influence and the influence of what they believe. It is a normal process of structured social interaction, with its many interconnected social webs or networks that they provide the means and opportunity to promote one's beliefs in the social, cultural, political and epistemic market places. However, some come to such market places with an already decided advantage as regards symbolic and institutional resources and social connections. Welch was a person with such personal and social advantages, as were the Flexner brothers, J. D. Rockefeller Snr. and Jnr., and others operating in the hospital-university-research institutional configuration.

For further studies of the Flexner Report and its various connections, influence and assumptions see:-

a H. D. Banta (1971) 'Medical Education. Abraham Flexner - a re-appraisal'.
Social Science and Medicine 5, p.655-61;

b H. S. Berliner (1976) 'A larger perspective on the Flexner Report'.
Int. J. Health Studies 5(4), p.573-92;

c H. L. Coulter (1973) op.cit. p.446-49;

d R. P. Hudson (1971) 'Abraham Flexner in perspective: American education 1865-1910'.
Bull Hist. Med. 46(6) Nov.-Dec., p.545-61;

e M. Kaufman (1976) op.cit. Ch. 11 p.164-82;

f S. J. Kunitz (1974) 'Professionalism and social control in the Progressive Era: the case of the Flexner Report'.
Social Problems 22(1) p.16-27;

g F. Parker (1961) 'Abraham Flexner (1866-1959) and Medical Education'.
J. Med. Ed. 36 (June) p.709-14.

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2. I. Waddington (1973) 'The struggle to reform the Royal College of Physicians, 1767-1771: a sociological analysis'. Med. Hist. 17 p.108.

3. G. Holmes (1982) 'Augustan England: Professions, State and Society, 1680-1730' George Allen and Unwin p.166-235.

4. O. W. Wangensteen and S. D. Wangensteen (1978) 'The Rise of Surgery: from empiric craft to scientific discipline'. Dawson.

5. C. L. Kronus (1976) 'The evolution of occupational power: an historical study of task boundaries between physicians and pharmacists'. Sociology of Work and Occup. 3(1) p.3-37.

6. B. Ehrenreich and D. English (1979) 'For Her Own Good'. Pluto Press. Ch. 2 'Witches, Healers and Gentlemen's Doctors', p.29-61.

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   b E. Clarke (1966) 'History of British Medical Education'. Brit. Jour. Med. Educ. 1 p.7-15.

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9. a J. R. R. Christie (1974) 'The origins and development of the Scottish scientific community 1680-1760'. Hist. Sci. 12 p.122-41.
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    b J. F. Kett (1964) 'Provincial medical practice in England, 1730-1815'. Jour. Hist. Med. 19 p.17-29.

11. a H. P. Tait (1966) 'Medical Education at the Scottish Universities to the close of the eighteenth century' in F. N. L. Poynter (ed) (1966) p.53-68.
    b I. Waddington (1973) op.cit. p.107-26.

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'Part II: the consequences of the Act'.
Med. Hist. 10 p.221-36.

13. G. V. Larkin (1983) 'Occupational monopoly and modern medicine'. Tavistock Pubs.

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16. N. Parry and J. Parry (1976) op.cit. p.48 referring to E. Freidson (1970)(b) p.132-36.

17. Sir G. Clark (1964) 'A History of the Royal College of Physicians of London' (3 vols). Clarendon Press Vol. 1 p.52.

18. Op.cit. p.54 (paraphrase only).

19. Op.cit. pp.24, 26, 54-55, 60-61, 63, 114, 116, 118, 145, 152, 157, 233ff, 249, 363.

20. See appendix 2 and section 5.6.1 on the Cholera Epidemic in 1853-54.

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c I. Waddington (1973) op.cit. p.107-26.
N.B. Waddington rightly argues that the 'general practitioner' (as a social role) existed well before the nineteenth century but not in the 'self-conscious', ideologically formative way that it did during that century.

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37. W. B. Walker (1956) op.cit. p.766.

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42. idem.

43. C. Newman (1959) op.cit. p.306.

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c E. Clarke (1966) op.cit. p.11-12.
d S. W. F. Holloway (1964) op.cit. p.320-22.
e C. Newman (1959) op.cit. p.306-307.
f W. B. Walker (1956) op.cit. p.730-71.

47. a M. J. Peterson (1978) op.cit. p.136-93.
b N. Parry and J. Parry (1976) op.cit. p.136-43.

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c C. Newman (1959) op.cit. p.308.

50. a Z. Cope (1973) op.cit. p.9.
b W. B. Walker (1956) op.cit. p.771-74.

51. N. Parry and J. Parry (1976) op.cit. p.126.

52. Sir J. Forbes (1857) 'Of Nature and Art in the Cure of Disease' pub. John Churchill, was one of the guiding stars in advocating reliance upon the 'vis medicatrix naturae' as the basis for a 'scientific' therapeutics. Forbes listed those diseases which had specific remedies and argued that nature was mainly able to cure the rest. Jacob Bigelow, by contrast (in 1835), listed those diseases which were self-limiting and presumed the rest to be correctable by medical art.
cf. J. Kett (1968) 'The Formation of the American Medical Profession'. Yale Univ. Press p.158 for this rather insightful comment.

53. M. Pelling (1983) 'Medical practice in the Early Modern Period: Trade or Profession?'
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54. A. Giddens (1979) 'Central Problems in Social Theory'. Macmillan Press Ltd. p.76-81.

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56. Op.cit. p.1-17.

57. A. Giddens (1979) op.cit. p.96.

58. I. Lakatos (1970) 'Falsification and the methodology of scientific research programmes'
in I. Lakatos and A. Musgrave (eds) (1970) p.116-32.

59. F. Bodman (1961) 'The Life and Times of Dr. Quin'.
Brit. Hom. Jour. 50(2) April p.73-82.

60. Op.cit. p.76. Dr. Unwin's enthusiasms can be found reported in 'The Lancet' (1836-37) Vol. 1 Oct. 10th p.142-44 and Oct. 22nd p.76 regarding his debates at the London Medical Society.

61. F. Bodman (1961) op.cit. p.76-77.

62. Op.cit. p.78.

63. C. F. Brockington (1966) 'Public health in the nineteenth century'. J. and A. Churchill. 2nd edition.

64. N.B. The D.N.B. (1896) Vol. 37 p.107 possibly misdates it as 1838.

65. Sir G. Clark (1966) 'A History of the Royal College of Physicians, London (Vol. 2)' Clarendon Press p.677-78.

66. F. Bodman (1961) op.cit. p.78.

67. Emmanuel Swedenborg (1688-1772) founded his Church of the New Testament, or New Church, on the basis of his 'revelations' as to the 'spiritual' interpretation of a select number of books from the Bible which he considered to be 'the word of God' in a special sense. These 'spiritual' meanings, originally adapted to angels, could become human spiritual knowledge too, through a special 'enlightenment' to which Swedenborg claimed to have the key. Churches of his followers originated in London in 1784 and were incorporated in 1821. They reached the U.S.A. in the 1790s and became nationally organized in 1817.

68. M. Mandelbaum (1971) 'Philosophic movements in the nineteenth century'
in C. Chant and J. Flavel (1980) p.1-44.

69. G. Rankin (1980) 'Homeopathy - popular medicine or science?' Unpub. ms., Dept. of Sociology and Social Anthropology, University of Keele p.2-3.
The 'Whig Aristocracy' are those high ranking, propertied, aristocratic families from whom the Whig (i.e. Liberal) Party drew much of its patronage and support.

70. J. Morrell and A. Thackray (1981) 'Gentlemen of Science'. Clarendon Press p.6.

71. G. Rankin (1980) op.cit. p.3.

72. F. Bodmin (1961) op.cit. p.79.

73. G. Rankin (1980) op.cit. p.5.

74. 'B.H.S. Minutes and Correspondence' Vol. 2 1848-50, reporting the Society's Annual Assembly, of 25th Aug. 1849 p.249-95. [N.B. 'B.H.S.: Minutes and Correspondence' is henceforth abbreviated to 'B.H.S.: M and C'.]

75. G. Rankin (1980) op.cit. p.6 referring to 'The London and Provincial Homoeopathic Medical Directory' (1855) p.65.

76. 'B.H.S.: M and C' Vol. 2 op.cit. p.249-95, over such issues as proxy voting to be extended to include Society rules, as well as financial reports and election of officers was defeated (p.268), whether to meet in Quin's home or not (p.250-51) and so on, expressed this inner power struggle.

77. Op.cit. p.304-14. Six of those who left were provincials and one was a new member living in London.

78. The protection association was originally begun to prevent Dr. Robert Hall being deprived of a diploma from St. Andrew's University. But see:-
a 'B.H.S.: M and C' Vol. 3 1851-1855, Aug. 7th (1851) p.1-5.
b Anonymous (1851) 'Proceedings of the Town Council of Edinburgh in reference to Homoeopathy' in J. R. Russell (ed) (1852) p.398-403.

c 'Alumnus' (1851) 'The New Test Act'
in J. R. Russell (ed) (1852) p.196-243.

d Anonymous (1851) 'The Royal College of Physicians of Edinburgh and Homoeopathy'
in J. R. Russell (ed) (1852) p.176-95.

e J. Y. Simpson (1851) 'Speech at the Medico-Chirurgical Society relative to Homoeopathy: with notes on the peculiar theological opinions of some disciples of Hahnemann, etc.' Sutherland and Knox.

f W. Henderson (1851) 'Letter to the President of the Medico-Chirurgical Society of Edinburgh on the recent speeches of Professors Syme and Simpson'. W. P. Kennedy.

g J. R. Russell (1851) 'A Letter to the President of the Royal College of Surgeons, on the late proceedings of the body, regarding Homoeopathic practitioners'. John Greig and Son.
N.B. J. R. Russell (1852) 'Homoeopathy in 1851'. James Hogg Appendix p.408-16 lists the male members and subscribers of the Protection Association as numbering 3,337 by Jan. 12th, 1852. This included nine peers, five M.P.s, 114 physicians and surgeons, 31 former Edinburgh graduates, 200 clergy, 48 magistrates and 71 army and navy officers.

79. 'B.H.S.: M and C' Vol. 2 (1850), Nov. 7th p.253 and Dec. 5th p.271. Dr. Young reported on such a group being presented a paper by Dr. Holland on 'An exposition and defence of Homoeopathic principles with remarks on the value of experience in the treatment of disease'.

80. 'B.H.S.: M and C' Vol. 5 (1857-63) passim.

81. Op.cit. Vol. 5 (1863-79), Oct. 8th (1863) p.1-18.

82. a 'B.H.S.: M and C' Vol. 6 1879-99.

b London School of Homoeopathy Minute Book.

c 'Morning Post' (1876) 16th Dec.

N.B. By the time of Quin's death the B.H.S. had 292 members: cf. F. Bodman (1961) op.cit. p.80.

83. Miscellaneous (1882) 'The Diploma of 'L.H.' of the London School of Homoeopathy - A Symposium'.
Brit. Jour. Hom. 40(160) p.156-89.

84. a D. Macrae (1861) 'Obstacles to the general adoption of homoeopathy'.
Brit. Jour. Hom. 19(76) p.202-16.

b A. C. Pope (1861) 'Ethical impediments to the progress of Homoeopathy throughout the profession'.
Brit. Jour. Hom. 19(75) p.95-106.

85. 'Editorial' 1843 Brit. Jour. Hom. 1 p.(iv).

86. G. Rankin (1980) op.cit. p.6-9, 12-13, 17-20.

87. Op.cit. p.12-13, 17-20.

88. Op.cit. p.18-19.

89. See Section 5.4.5.

90. A. Giddens (1979) op.cit. p.188.

91. Op.cit. p.187.

92. Lancet (1834-1835) Vol. 1 p.320-22.

93. Op.cit. p.322.

94. Op.cit. p.932.

95. Op.cit. p.717.

96. Lancet (1877) Vol. 1 June 2nd p.811.

97. idem.

98. Lancet (1836-1837) Vol. 1 p.143.

99. Op.cit. Vol. 1 p.261.

100. idem.

101. Lancet (1836-1837) Vol. 1 Sat. Feb. 20th p.840.
From a paper by Dr. Johnson, at the Westminster Medical School, on 'The New Quackery' (i.e. Hahnemannianism).

102. Op.cit. Vol. 1 p.118-25.

103. Op.cit. Vol. 1 p.122-23.

104. Lancet (1846) Vol. 2 Sat. Nov. 14th p.537-39.

105. Op.cit. p.538.

106. Lancet (1846) Vol. 1 p.70.

107. J. Forbes (1846) 'Homoeopathy, Allopathy and 'Young Physic''. Brit. For. Med. Rev. p.225-65.

108. D.N.B. (1889) Vol. 19 p.406.

109. Lancet (1846) Vol. 1 p.370.

110. Lancet (1850) Vol. 1 Sat. 7th Sept. p.300-302.

111. idem.

112. For examples of further inaccuracies about homeopathic dilutions see:-
a Lancet (1840) Vol. 2 Sat. 18th April p.142-43.
b Lancet (1843) Vol. 2 Sat. 27th May p.314-17 (Editorial).

113. D. McQuail (1983) 'Mass Communication Theory: an introduction'. Sage Pubs. p.201-202, which refers to:-
E. Noelle-Newman (1974) 'The Spiral of Silence: a theory of public opinion'.
Journal of Communication 24 p.43-51.

114. E. M. Little (1932) 'History of the British Medical Association, 1832-1932'.
B.M.A. p.19.

115. Op.cit. p.21-22.

116. P. Vaughn (1959) 'Doctors' Commons: a short history of the British Medical Association'. Heinemann p.89.

117. idem.

118. Anonymous (1851) 'The Brighton Protest Analysed'
in J. R. Russell (ed) (1852) p.285-286.

119. Op.cit. p.288.

120. See ch. 4 section 4.3

121. W. E. Houghton (1957) 'The Victorian Frame of Mind. 1830-1870'. Yale University Press.

122. A. C. Pope (1861) 'Ethical impediments to the progress of Homoeopathy throughout the profession'.
Brit. Jour. Hom. 19(75) p.96-97.

123. cf. Chapter 6 section 6.4.5(ii) especially references 142-150 for evidence of this claim.

124. J. Y. Simpson (1851) 'Speech at the Medico-Chirurgical Society Relative to Homoeopathy: with notes on the peculiar theological opinions of some disciples of Hahnemann, etc.'. Sutherland and Knox p.3 (Introduction).

125. J. Y. Simpson (1844) 'Homoeopathy: its tenets and tendencies, theoretical, theological and therapeutical'. Simpkin, Marshall and Co. (3rd edition, 1853).

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127. For example:-

a J. Y. Simpson (1851) 'Speech at the Medico-Chirurgical Society relative to Homoeopathy: with notes on the peculiar theological opinions of some disciples of Hahnemann, etc.'. Sutherland and Knox.

b W. Henderson (1851a) 'Letter to the President of the Medico-Chirurgical Society of Edinburgh on the recent speeches of Professors Syme and Simpson'. W. P. Kennedy.

c W. Henderson (1851b) 'Letter to the Patrons of the University on the Late resolution of the medical faculty' reported in Brit. Jour. Hom. Vol. 30 p.450-59.

d J. R. Russell (1851) 'A letter to the President of the Royal College of Surgeons, on the late proceedings of the body, regarding Homoeopathic practitioners'. John Greig and Son.

e W. T. Gairdner (1851) 'Edinburgh essay on Homoeopathy'. A. and C. Black.

f J. Hogg and J. Brown (1851) 'Correspondence between Professor Christian and Dr. George E. Stewart on Homoeopathy'. Edinburgh.

g Anonymous 'A' (1851) 'Trials and Confessions of Professors Syme, Christian and Simpson' in J. R. Russell (ed) (1852) p.343-70.

h Anonymous 'B' (1851) 'Proceedings of the Town Council of Edinburgh in reference to Homoeopathy' in J. R. Russell (ed) (1852) p.398-403.

i Anonymous 'C' (1851) 'The Royal College of Physicians of Edinburgh and Homoeopathy' in J. R. Russell (ed) (1852) p.176-95.

j 'Alumnus' (1851) 'The New Test Act' in J. R. Russell (ed) (1852) p.196-243.

k W. Henderson (1852) 'Reply to Dr. Simpson's pamphlet on Homoeopathy, and second edition of the letter to the President of the Medico-Chirurgical Society, with a postscript'. Edinburgh.

128. D. N. B. Vol. 25 p.406-407.

129. J. D. Comrie (1932) 'History of Scottish Medicine'. (Vol. 2). Bailliere, Tindall and Cox p.596.

130. D. N. B. Vol. 55 p.266-67.

131. D. N. B. Vol. 10 p.290-91.

132. W. Henderson (1851a) op.cit. p.9.

133. J. Forbes (1846) 'Homoeopathy, Allopathy and the 'Young Physic''.
Brit. For. Med. Rev. 21 p.225-65.

134. E. J. Evans (1982) op.cit. p.289-90.

135. Op.cit. p.290.

136. W. M. Frazer (1950) 'A History of English Public Health, 1834-1939'. Bailliere, Tindall and Cox p.64-65.

137. A. Lilienfeld (1982) 'Ceteris Paribus: the evolution of the clinical trial'.
Bull. Hist. Med. 56 p.9.

138. cf. D. N. B. for more detail on the various committee members. Note: Paris, Babington and Tweedie were nominated by the R.C.P. (London). Clark, Alderson, Arnott, Baley, Simon, Owen and Farr were nominated by the president of the G.B.H. Lawrence was selected from a list supported by the R.C.S. (London). Ward and Bacot were nominated by the Society of Apothecaries. There were, in addition, Dr. R. D. Thompson, Dr. Hassell and Mr. Glaisher who were appointed to conduct chemical, microscopical and meteorological inquiries, respectively, in connection with the epidemic.
cf. (a) General Board of Health 1854-55 'Accounts and Papers' Vol. 45, 12th Dec. 1854-14th Aug. 1855;
(b) 'A letter of the President of the General Board of Health to the Rt. Hon. Viscount Palmerston with a report from Dr. Sutherland on epidemic cholera in the metropolis (1854)'

139. 'Report on the results of the different methods of treatment pursued in Epidemic Cholera, addressed to the President of the General Board of Health by the Treatment Committee of the Medical Council (1855)' p.8. [Abbreviated to 'Treatment Committee Report (1855)']

140. a 'Treatment Committee Report (1855)' op.cit. p.1-5.
b 'Report on the treatment of Epidemic Cholera in the provinces throughout England and Scotland in 1854, being supplementary to the Metropolitan Report addressed to the President of the General Board of Health, by the Treatment Committee (1855)' p.1-15. [Abbreviated to 'Treatment Committee Supplementary Report 1855'].

141. 'Treatment Committee Supplementary Report (1855)' p.2-5.

142. idem.

143. idem.

144. Op.cit. p.6.

145. idem.

146. Op.cit. p.8.

147. idem.

148. Op.cit. p.15.

149. idem.

150. 'Treatment Committee Report (1855)' op.cit. p.15.

151. Op.cit. p.10 and 11.

152. 'Reviews: 'Report of the Committee for Scientific Inquiries in relation to the Cholera Epidemic of 1854, presented to both Houses of Parliament by command of Her Majesty (1855)'.' Full text reported in: Brit. Jour. Hom. 14(55) 1856 p.102-24. [Abbreviated to 'Scientific Inquiries Committee Report 1855'].

153. Dr. MacLaughlin's letter to Mr. Cameron, 22nd Feb. 1855, is quoted in:-

a 'Parliamentary returns of the Homoeopathic treatment of cholera'. Brit. Jour. Hom. (1855), 13(54) p.674-88, esp. p.677, 679-80. [Abbreviated to 'Parliamentary Returns (Homoeopathic) 1855'].

b 'The Fifth Annual Report of the London Homoeopathic Hospital, 32, Golden Square (submitted to the General Meeting on 6th June) 1855' p.8-22, esp. pp.11 and 14. [Abbreviated to 'Fifth Annual Report of the L.H.H. (1855)'].

154. British Homoeopathic Society Minute Books Vol. 3 April 3rd (1855). [Abbreviated to 'B.H.S. Min. Bks.' henceforth].

155. idem.

156. 'Parliamentary Returns (Homoeopathic) 1855' p.678. [N.B. The 'Key' and alphabetically listed columns were not part of the original document. I provided these for technical reasons of presentation.]

157. Op.cit. p.679. Comparative results of homeopathy and 'allopathy' during cholera epidemics in Russia, Italy and France during 1832 can be found in Appendix 2.

158. 'Fifth Annual Report of the L.H.H.' (1855) p.14.

159. idem.

160. 'Parliamentary Returns (Homoeopathic) 1855' p.675-76.

161. Op.cit. p.681.
N.B. No record of this internal correspondence can be found in any of the General Board of Health volumes for 1853-56.
Thus there is no record of who proposed and seconded the motion. Unlike Robert Eagle (1978) 'Alternative Medicine: a guide to the medical underground' Futura Pubs. Ltd. I cannot assert, as he does, that it was John Ayrton Paris who 'saw to it that these favourable statistics were kept out of the official record' (p.62).

162. C. Russell (1983) 'Science and Social Change, 1700-1900'. Macmillan Press Ltd. Chapters 5, 9 and 10.

163. Hansard Parliamentary Debates. 3rd session (35) Vol. 138, 3rd May-21st June 1855 p.557-58.

164. 'Parliamentary Returns (Homeopathic) 1855' p.674.

165. 'O.G.M. British Homoeopathic Society' Minute Books, Vol. 3, 1855; 18th May.
This was Mr. Cameron reporting a conversation with an unnamed M.P.

166. Lancet (1855) Vol. 1 Sat. 9th May p.520.

167. D. L. Cowen (1969) op.cit. p.32.

168. M. J. Peterson (1978) op.cit. p.36.

169. I. Waddington (1979) op.cit.

170. 'The Medical Act'.
Brit. Jour. Hom. (1858) 10(66) p.536.

171. Op.cit. p.537-44.

172. Op.cit. p.540. Part of a letter from Dr. J. Macrobin, of Marischal College, to Mr. C. T. Harvey.

173. Op.cit. p.542.

174. a Op.cit. p.544.
b Sir J. Weir (1932) 'British Homoeopathy during the last hundred years'.
B.M.J. 2 Sept. 24th p.604.
c It is worth noting that William Francis Cowper had become the President of the General Board of Health about August 1855, replacing Sir Benjamin Hall who was disgraced over the affair with the homeopathic returns.
cf. D.N.B. (1901) Supplement Vol. 2 p.74-75.

175. 'The Medical Act'.
Brit. Jour. Hom. (1855) 10(66) p.545.

176. Op.cit. p.550.

177. 'An Act to Regulate the Qualifications of Practitioners in Medicine and Surgery' (2nd August 1858). [It took effect from 1st October 1858.]

178. Op.cit. 'Penalty for falsely pretending to be a registered person'. Clause XL. It was difficult to prove that such a person was not just (a) claiming a title they did not have but also (b) pretending to be registered. If convicted they could be fined up to £20.

179. 'The Medical Act and Medical Orthodoxy'.
Brit. Jour. Hom. (1859) 17(70) p.681.

180. a 'The opposition to Homoeopathy' (part 1: p.209-32).
Brit. Jour. Hom. 30(120) 1872 p.213-14.
b J. J. Drysdale (1881) 'On Consultation between Allopathic and Homoeopathic Medical Men'.
Brit. Jour. Hom. 39(157) p.207.

181. 'The opposition to Homoeopathy' (1872) op.cit. p.215.

182. Op.cit. p.213.

183. 'Consultations between homoeopathists and allopathists'.
Brit. Jour. Hom. 16(65) 1858 p.473.

184. J. J. Drysdale (1881) op.cit. p.205.

185. 'Consultations between homoeopathists and allopathists' 1858 op.cit. p.453-84, reported of the South Midland Branch of the B.M.A. on 21st May 1858.

186. Op.cit. p.482.

187. T. Hayle (1860) 'Some remarks on the present state of Homoeopathy'.
Brit. Jour. Hom. 18(71) p.94.

188. 'The opposition to homoeopathy' (Part 2: p.484-95).
Brit. Jour. Hom. 30(121) p.486 and 490.
The above writer's idea that homeopathy could only be eliminated by recognizing it is quite insightful. However, there are other ways of eliminating an oppositional group; such as (a) ignoring it completely; (b) absorbing it utterly; (c) ignoring or combating it and waiting for it to move towards your own position as much as possible and then absorbing it. Various forms of co-operation and an increase in positive, non-polemical, ecumenical discussion would advance such a project as (c). Route (b) was certainly proposed as a future

possibility by J. J. Drysdale (1881) op.cit. p.209. The (c) route seemed to operate very much for homoeopathy in the U.S.A. except that it functioned to draw them into a vulnerable position and weaken their numbers. This resulted in their eventual rejection and denied them the 'legitimacy' they had compromised so much for (cf. Ch. 4).

189. C. W. Luther (ed) (1848) 'A Concise View of the System of Homoeopathy, and Refutation of the Objections Commonly Brought Against It'. James McGlashan (2nd edition, revised).
N.B. The above work incorporated a pamphlet by C. W. Luther entitled 'Homoeopathy explained and objections answered' in 1840. So, it appears that the 1848 'A Concise View . . . . . .' was based upon the arguments in the 1840 pamphlet.

190. The disapproved of therapies were bleeding, counter irritation, external application for external symptoms, palliatives, salivation, tonics, emmenagogues, antibilious medicines, purgatives and the indiscriminate use of mineral waters and sea bathing.

191. C. W. Luther (ed) (1848) op.cit. p.144-168. (N.B. He refers back to previous chapters in his answers if he has already substantially dealt with the objection there.)

192. Op.cit. p.66-76.

193. Op.cit. p.147.

194. Op.cit. p.53-57.

195. Op.cit. p.147-48.

196. Op.cit. p.148.

197. Op.cit. p.138.

198. Op.cit. p.149.

199. idem.

200. idem and footnote *p.149-50.

201. Op.cit. p.150.

202. Op.cit. p.151-52.

203. Op.cit. p.152-53.

204. Op.cit. p.153.

205. Op.cit. p.156.

206. Op.cit. p.156-62.

207. Op.cit. p.162-64.

208. Op.cit. p.165.

209. Op.cit. p.165-68 plus appendix 1 'Some statistical data relating to Homoeopathy' p.169-236.

210. 'Reviews' Brit. Jour. Hom. 5(19) 1847 p.108.

211. J. H. Clarke (ed) (1882) 'Odium Medicum and Homoeopathy'. Homoeopathic Pub. Co.

REFERENCES TO CHAPTER 6

1. For example, Norbert Elias has elucidated what he terms the 'monopoly mechanism' in his studies of the psycho- and sociogenesis of manners and the formation of the state. David Martin has also included within a very general theory of secularization a notion of 'secular monopoly' and its sociohistorical variations. Although both are extensive studies in the historical sociology of formative power in the political and cultural spheres of social systems they both employ an implicit notion of marginalization in order to describe their respective phenomena in terms of the monopolization process.

cf. a) Norbert Elias (1982) 'The Civilizing Process, Vol. 2: State Formation and Civilization', trans. by E. Jephcott. Basil Blackwell Pub. Ltd. (esp. ch. 2 on the Sociogenesis of the State, p.91-225. The monopoly mechanism is described on p.104-16).
b) David Martin (1978) 'A General Theory of Secularization'. Basil Blackwell (esp. ch. 2 A Theory of Secularization: Basic Patterns, p.12-99, and ch. 5 The Pattern of Secular Monopoly, p.209-243).
c) And work already referred to in chapter 1 such as J. C. Berlant (1975) and M. S. Larson (1977).

2. Bearing in mind that terms such as 'unorthodox', 'irregular', 'charlatan', 'quack' and so on are part of a vocabulary of abuse historically constructed by the ideological work of those practitioners who perceived themselves as the formulators, bearers and transmitters of 'orthodox', 'regular', 'scientific' medicine.

3. a Robert E. Park first used the term 'marginal man' in referring to the bicultural hybrid produced by migration from one culture to a different one. i.e. 'Human Migration and the Marginal Man', Am. Jour. Soc. Vol. 33 (1927-28) p. 892.

b E. V. Stonequist (1937) 'The Marginal Man'. Charles Scribner's Sons, who, due to the assumptions of a cultural functionalism, identified social maladjustment as characteristic of marginality. Of course, there is no necessary link between these two phenomena.

c M. M. Goldberg (Feb. 1941) 'A Qualification of the Marginal Man Theory'.
Am. Soc. Rev. 6, p.53-58.
Goldberg argues that being a member of a marginal culture may have its social strains but in no way can its existence be considered as socially pathological because socialization processes render participation quite 'normal' in its subjectively learned aspects. Like non-marginal dominant groups, a marginal collectivity also provides for the psychological and social security of its members, as well as providing outlets to express cultural interests in a way that minimises their distinctiveness as individuals and as groups.

d A. W. Green (1947/48) 'A Re-examination of the Marginal Man Concept'.
Soc. Forces 26 p.167-71.

Green argues that the 'Negro problem' is in fact a 'White created problem'. Read 'homeopath' for 'negro' and 'regular practitioner' for 'White' and we have some indication of the structural condition of the marginality of 19th century homeopaths.

e E. C. Hughes (1949) 'Social Change and Status Protest'. Phylon 10 p.59-65.
Hughes extends the idea of marginality to multiple status and group membership, not just two conflicting groups.

f D. I. Golovensky (1951-52) 'The Marginal Man concept. An analysis and critique'.
Soc. Forces 30 p.333-39.
Golovensky makes the important caveat that dominant cultures are not a uniform homogeneity in relation to marginal cultures.

h R. D. Wright and S. N. Wright (1972) 'A plea for a further refinement of the Marginal Man theory'.
Phylon 33 p.361-68.
The Wrights recognise that marginality not only occurs outside dominant groups (e.g. racial groups) but also within a dominant group (e.g. occupational groups) and that marginality can operate at many different levels (e.g. cultural, social and psychological).

i N. P. Gist and R. D. Wright (1973) 'Marginality and Identity'. E. J. Brill.
Gist and Wright apply the theoretical insights of Wright and Wright (1972) op.cit. to the problems of the racial minority of Anglo-Indians in the sub-continent of India and described the dynamic contingencies of marginality in terms of role and status ambiguities.

4. A. Giddens (1979) 'Central Problems in Social Theory'. Macmillan p.88-94.

5. A. Giddens (1976) 'New Rules of Sociological Method'. Hutchinson p.111.

6. cf. Chapter 4, section 4.5.1.

7. cf. Chapter 1, section 1.5.

8. cf. Chapter 5, section

9. 'Science and Sectarianism'.
Brit. Jour. Hom. 26 (105) 1868 p.428-45.

10. A. C. Pope (1861) 'Ethical impediments to the progress of Homeopathy throughout the profession'.
Brit. Jour. Hom. 19 (75) p.95-106.
Pope was very much concerned that homeopaths conduct themselves in such a way towards regular practitioners, that there be nothing in their attitude or behaviour which prevented homeopathy being given a hearing by them. He recognised that although they had much more in common than either side generally supposed, their chief difference was still the theory on which remedies

were to be chosen and prescribed. However, the cultivation of mutual respect, confidence and sympathy would place their professional character and conduct beyond suspicion such that the respect and esteem of their regular medical 'brethren' may be gained.

11. a 'The Diploma of 'L.H.' of the London School of Homeopathy - a Symposium'.
Brit. Jour. Hom. 40 (160) 1882 p.156-89.
b W. G. Rothstein (1972) 'American Physicians in the Nineteenth Century: from Sects to Science'. Johns Hopkins University Press, ch. 12 p.230-246.

12. a Dr. Hayle (1860) 'Some remarks on the present state of Homeopathy'.
Brit. Jour. Hom. 18 (71) p.92-100.
b D. Macrae (1861) 'Obstacles to the general adoption of Homeopathy'.
Brit. Jour. Hom. 19 (76) p.202-16.
c A. C. Pope (1861) op.cit.
d 'Science and Sectarianism' (1868) op.cit.
e Dr. Richardson (1877) 'The Homeopathic Schism'.
Lancet 1 June 2nd p.816-17.
In which he reports a meeting with the Vice-President of the British Homeopathic Scoiety, Dr. George Wyld, which surprised him as to the closeness of homeopathy with regular practice. The editorial response of the Lancet was to insist that if homeopaths wanted to return to the ranks of legitimate practitioners then they must renounce homeopathy in name and deed. Thus brought a reply from Dr. Wyld (Lancet Vol. 1 June 9th 1877, p.850, 859-60) in which he claimed to surrender no principles of homeopathy, only that they were not exclusive of other principles.

13. A. Giddens (1979) op.cit. p.93.

14. idem.

15. Op.cit. p.100-101.

16. M. S. Archer and M. Vaughn 'Domination and Assertion in Educational Systems' in Earl Hopper (ed) (1971) 'Readings in the Theory of Educational Systems'. Hutchinson, p.58.

17. A. Giddens (1976) op.cit. p.110-12.

18. A. Giddens (1979) op. cit. p.193-95.

19. A. Giddens (1976) op.cit. p.112.

20. Depending upon the resources available to either side at the local level the outcome of this trade union tactic was mixed. For example in the U.S.A. in 1857 some homeopaths tried to gain the facility to treat patients in a Cook County Hospital,

still being built at the time. The county board of health gave them 25% of the beds, whereupon the regulars withdrew and succeeded in having it open on their terms - no homeopaths. Whereas, during the 1866 cholera epidemic the N.Y. homeopaths, with the aid of prominent lay supporters, overcame the opposition of the N.Y. Academy of Medicine, and the Metropolitan health board allowed homeopaths to practice in two city hospitals. cf. W. G. Rothstein (1972) op.cit. p.233.

21. a W. J. Reader (1966) 'Professional Men'. Weidenfeld and Nicolson, passim.
    b S. Rothblatt (1976) 'Tradition and Change in English Liberal Education: an essay in history and culture'. Faber.

22. This is certainly the impression one gets from the history of medicine in the United States.
cf. W. G. Rothstein (1972) op.cit., passim.

23. A. Gidden (1979) op.cit. p.83.

24. a A. Giddens (1979) op.cit. p.145-50.
    b A. Giddens (1981) 'A Contemporary Critique of Historical Materialism'. Macmillan Press Ltd. p.56-68.
N.B. Giddens uses the terms 'reciprocity' and 'dialectic' of control but prefers the descriptive term 'dialectic of control'. I prefer the term 'reciprocity of control' because it avoids unnecessary Hegelian philosophical overtones which hinders the specific meaning I want to give. The original meaning of dialectic refers to a type of argument. I rather want to propose a matter of social ontology not philosophic method.

25. A. Giddens (1981) op.cit. p.61.

26. N. Parry and J. Parry (1976) 'The Rise of the Medical Profession'. Croom Helm.

27. For example:-
    a Joseph H. Green (1847) 'Mental Dynamics or Groundwork of a Professional Education'. W. Pickering, London.
    b John Kidd (1841) 'Observations on Medical Reform'. Churchill, London.
    c James Syme (1854) 'Letter to the Lord Viscount Palmerston on Medical Reform'. Edin.
    d John Ware (1847) 'Discourse on Medical Education and the Medical Profession'. Munroe, Boston.

28. A. Giddens (1979) op.cit. p.42.

29. D. Knoke and J. R. Wood (1981) 'Organized For Action'. Rutgers University Press p.1-29 provides theoretical and empirical sociological synthesis of recent work on voluntary associations of which professions are a sub-type.

30. See Chapter 3 for the evidence regarding this thesis, which is clearly stated in section 3.8.

31. a A. Giddens (1981) op.cit. p.26-29.
b P. L. Berger and T. Luckmann (1971) 'The Social Construction of Reality'. Penguin University Books, p.122-34, concerning the conceptual machineries to legitimate symbolic universes, and also how power is related to this and the handling of cognitive deviance.

32. E. Jameson (1961) 'The Natural History of Quackery'. Michael Joseph, passim.

33. This has been discussed in sections 6.1-6.2.

34. A. J. Weigert (1981) 'Sociology of Everyday Life'. Longman, p.41.

35. a Zbigniew Brzezinski (1962) 'Deviation control: a study in the dynamics of doctrinal conflict'.
Am. Pol. Sci. Rev. 56(1) p.5-24.
b Dwight Harshbarger (1973) 'The Individual and Social Order: Notes on the management of Heresy and Deviance in Complex Organizations'.
Human Relations 26(2) p.251-69.

36. J. R. Ravetz (1973) 'Scientific knowledge and its social problems'. Penguin University Books, p.101-104 for discussion of the tacit component of learned techniques; p.75-76, 173-76 for discussion of the craft component in scientific work and methods of inquiry.

37. A. Giddens (1979) op.cit. p.218. 'Routine' is relatively unmotivated in the same sense that the reproductions of a language - unless under threat of extinction - does not require the securing of motivation amongst the language-users to reproduce it.

38. Op.cit. p.122.

39. Op.cit. p.219. The first part of this quotation was stated in relation to a preliminary outline of the conditions for the cognitive and social functioning of a medical cosmology by a believer committed to it (cf. Chapter 3, section 3.2).

40. idem.

41. Homeopathy also challenged the Bacteriological-Laboratory cosmologies but not in a fundamental sense. This was because by that time the professional homeopaths had accommodated quite considerably to the criteria of 'professionalism' and 'scientific' medicine established by the regular practitioners and researchers.

42. Isabel Menzies (1970) 'The Functioning of Social Systems as a Defence Against Anxiety'. Tavistock, passim.

43. P. L. Berger and T. Luckmann (1971) op.cit. p.124-25.

44. Op.cit. p.126-127.

45. Op.cit. p.130-33. Berger and Luckmann use the term 'nihilation' to refer to the conceptual elimination of a deviant symbolic universe. Given the differentials of power and reciprocal nature of control mechanisms I think it wiser to (a) consider 'nihilation' as an (usually unachievable) ideal goal and (b) empirically more accurate to refer to 'de-legitimation' as a function of the anxiety defence mechanism of heresy repression.

46. Op.cit. p.130-31.

47. a R. G. A. Dolby 'Reflections on Deviant Science' in Roy Wallis (ed) (1979) 'On the Margins of Science: the social construction of rejected knowledge'. Sociological Review Monographs 27. University of Keele, p.9-47.
b R. Wallis and P. Morely (1976) 'Marginal Medicine'. Free Press Introduction, passim.

48. A number of references in this vein can be found in chapters four and five.

49. P. L. Berger and T. Luckmann (1971) op.cit. p.132.

50. Chapter 4 sections 4.4.

51. a R. T. Hayle (1860) 'Some remarks on the present state of homeopathy'.
Brit. Jour. Hom. 18(71) p.92-100.
b The Opposition to Homeopathy' part 2.
Brit. Jour. Hom. 30(121) 1872 p.484-95.

52. Robert M. Theobold M.A., M.R.C.S. (England) (1859) 'Homeopathy, Allopathy and Experience: a critique of Sir John Forbes' 'Nature and Art in the Cure of Disease'; and an exposition of Homeopathy'. Leath and Ross, London.

53. Dr. T. Hayle (1860) op.cit. p.94.

54. 'Science and Sectarianism'.
Brit. Jour. Hom. 26(105) 1868 p.441.

55. Imre Lakatos (1976) 'Proofs and Refutation'. C.U.P. pp.14-26, 42-43, 83-86 were the original source of the 'monster-barring' idea. However, my use widens its scope to more socio-cognitive and ideological spheres of conflict. In these arenas of ideological warfare and professional section interests there was more at stake than either personal reputation or the theoretical purity of logical proofs.

56. Erving Goffman (1968) 'Stigma: notes on the management of spoiled identity'. Penguin Books.
This is the most thoroughgoing analysis of face-to-face interaction contexts in which 'normal' and 'abnormal' people meet and the various ways the stigmatized person manages to shore up his/her precarious social and personal identity. However, his study lacks any theory of power and institutions which wield it in order to give certain identities a higher stigma-profile in the effort to mobilize public biases against specific 'deviant' groups who appear threatening to the social order or to some relatively powerful sectional interest groups within it.

57. Edwin M. Schur (1980) 'The Politics of Deviance: stigma contests and the uses of power'. Prentice-Hall, passim.

58. ibid. p.4.

59. H. Garfinkel (1956) 'Conditions of successful degradation ceremonies'.
Am. Jour. Sociology 61(5) March p.420.

60. M. Douglas (1966) 'Purity and Taboo'. R.K.P. p.161.

61. Op.cit. p.140.

62. a J. H. Clarke (1882) 'The Jubilee Meeting of the British Medical Association'.
Brit. Jour. Hom. 40(162) p.382-89.
b W. G. Rothstein (1972) op.cit. p.301-305.

63. J. H. Clarke (1882) op.cit. p.384-85.

64. M. Douglas (1966) op.cit. p.36.

65. H. L. Coulter (1973) 'Divided Legacy' Vol. 3 McGrath Pub. Co. p.152.
Also see Chapter 4 section 4.3.1.

66. H. L. Coulter (1973) op.cit. p.119-24.

67. a Brian Taylor (1976) 'Conversion and Cognition'.
Social Compass 23p.5-22.
b Brian Taylor (1978) 'Recollection and membership: convert's talk and the ratiocination of commonality'.
Sociology 12 p.316-24.

68. T. S. Kuhn (1970) 'The Structure of Scientific Revolutions'. University of Chicago Press.

69. J. R. Ravetz (1973) op.cit. 364-402.

70. B. Barnes and S. Shapin (eds) (1979) 'Natural Order'. Sage Publications.

71. A. Giddens (1979) op.cit. p.216-225.

72. D. Davidson (1973) 'On the very idea of a conceptual scheme'. Presidential Address to the 7th Annual Eastern Meeting of the American Philosophical Association.

73. D. L. Phillips (1979) 'Wittgenstein and Scientific Knowledge: a sociological perspective'. cf. Chapter 5 'Paradigms and Incommensurability' p.93-118.

74. Op.cit. p.106.

75. To argue this way is to fall into structural-functional discourse about the internalized motivational and normative consensus upon which social order is based. On the contrary, social and system integration can include conflict and commitment to norms for reasons of quite a calculative kind. It is preferable, as Giddens argues, to discuss legitimation, ideology, sectional interests and power differences in order to theorize about the systemness of social interaction. cf. A. Giddens (1979) op.cit. p.96-130, esp. p.101-103.

76. A. Giddens (1979) op.cit. p.24-25, 57-58.

77. Eileen L. McDonagh (1976) 'Attitude changes and paradigm shifts: Social Psychological foundations of the Kuhnian thesis'.
Soc. Stud. Sci. 6 p.51-76.

78. The membership qualification of such homeopathic organizations as the A.I.H. and B.H.S. would probably tend to filter out the poorer quality converts from regular medicine. Lay homeopathic organizations such as the E.H.A. may have then attracted them but this is only a reasonable speculation at this point. Obviously some biographical and prosopographical research could suggest some probability as to such a hypothesis. Also see sections 4.3 and 5. for comments on the A.I.H. and B.H.S. membership regulations.

79. a 'Dr. Ransford's reasons for embracing homeopathy' in J. R. Russell (ed) (1852) p.244-60. Abbreviated to 'Ransford's reasons' (1851).
b W. H. Holcombe (1866) 'How I became a Homeopath'. Henry Turner and Co.

80. 'Ransford's reasons' (1851) p.244.

81. idem.

82. idem.

83. Op.cit. p.258-60.

84. Op.cit. p.245-46.

85. Op.cit. p.246.

86. Op.cit. p.250.

87. Op.cit. p.251.

88. Op.cit. p.253.

89. a Andrew Combe was not a practising homeopathist. As a therapeutic sceptic in the tradition of John Forbes, he was agnostic towards the claims of homeopathy and argued that its essential claim - the similia principle - should be scientifically tested. cf. Andrew Combe (1846) 'On the Observation of Nature in the Treatment of Disease' in J. R. Russell (1851) op.cit. p.83-123, originally in the Brit. For. Med. Rev. April 1846.

b J. J. Russell is more likely to be J. R. Russell, also Edinburgh trained and one of the editors of the Edinburgh-based British Journal of Homeopathy, begun in 1843.

90. Op.cit. p.253.

91. Op.cit. p.255.

92. Op.cit. p.258.

93. Op.cit. p.260.

94. Op.cit. p.258.

95. idem.

96. idem.

97. Op.cit. p.245-46, 248, 251, 258-60.

98. W. H. Holcombe (1866) op.cit. p.4.

99. Op.cit. p.5.

100. idem.

101. idem.

102. A. J. Youngson (1979) 'The Scientific Revolution in Victorian Medicine'. Croom Helm Chapter 6 p.212-30.

103. a T. S. Kuhn 'The function of dogma in scientific research' in A. C. Crombie (ed) 1963 'Scientific Change' Heinemann p.347-69.

b T. S. Kuhn (1970 second ed.) 'The Structure of Scientific Revolutions'. University of Chicago Press pp10, 136-43, 144.

104. a B. Barnes (1982) 'T. S. Kuhn and Social Science'. Macmillan Press Ltd. passim.

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105. W. H. Holcombe (1866) op.cit. p.12.

106. Op.cit. p.13.

107. Op.cit. p.14.

108. Op.cit. p.15.

109. idem.

110. Op.cit. p.19.

111. idem.

112. idem.

113. Op.cit. p.20. Reference to Holcombe can be found in T. L. Bradford (1892) 'Homeopathic Bibliography of the United States'. Boericke and Tafel.

114. Op.cit. p.21.

115. J. R. Gusfield (1967) 'Moral Passage: the symbolic process in public designations of deviance'. Social Problems 15(2) p.175-88.

116. P. L. Berger and T. Luckmann (1971) op.cit. p.179-80.

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118. J. R. Ravetz (1973) op.cit. p.386-97.

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120. Op.cit. p.98-99.

121. Op.cit. p.98-102 and 104.

122. (Editorial) 'Homoeopathy in 1876'. Brit. Jour. Hom. 34(139) 1876 p.1-10. pp.9-10 represent the spread of homeopathy in terms of 'a creed and a practice, a faith to live and act by' (p.9).

123. G. Rankin (1980) 'Homeopathy - popular medicine or science?' Unpub. ms. Dept. Sociology and Anthropology, Univ. of Keele p.14

124. Dr. Elb (1868) 'Similia Similibus Curantur: a confession, though not a confession of faith'.
Brit. Jour. Hom. 26(105) p.37.
This work also advocated that homeopathy be interpreted patho-physiologically, making full use of all the aids to diagnosis of clinical medicine, in order to more scientifically investigate and apply the 'three cardinal points' of Hahnemann's theory; 'the law of similarity, the proving of drugs on the healthy subject, and the sole employment of single proved remedies' (p.377).

125. (Editorial) 'The Opposition to Homoeopathy'.
(Part 2) Brit. Jour. Hom. 30(121) 1872) p.48.

126. The homeopaths were within 'orthodoxy' in so far as they were often members of surgical and medical voluntary associations in addition to being qualified and licensed by regular medical institutions prior to their 'conversion' to homeopathy.
They were outside 'orthodoxy' in so far as they had to organize separate voluntary medical associations, hospitals, dispensaries, periodical journals and book publications.

127. Homeopaths regularly referred to themselves as the 'New School' of medicine and the regulars as the 'old school'.
cf. C. Neidhard (1842) 'An Answer to the Homeopathic Delusions of Dr. Oliver Wendell Holmes'. J. Dobson Philadelphia p.20; and 'Science and Sectarianism' (1868)
Brit. Jour. Hom. 26(105) p.430.
In so far as they agreed that their rejection was analogous to that experienced by men such as Harvey and Galileo and that 'orthodox' medicine needed a reformer such as Newton, they can be reasonably interpreted as understanding themselves as medical reformers analogous to the Reformers of the 16th century. cf. A. H. Okie (1842) 'Homoeopathy: with particular reference to a lecture by O. W. Holmes'. Otis Clapp, Boston, p.47 and J. R. Russell 'Homoeopathy via Young Physic' in J. R. Russell ed (1852) op.cit. p.139.

128. F. H. Garrison (1917) 'An Introduction to the History of Medicine'. W. B. Saunders Co. p.608-703 for a factological hagiography of these innovations in surgery, bacteriology and other specialist disciplines of medicine generally.

129. D. Matza (1969) 'Becoming Deviant'. Prentice-Hall, where it is said that 'becoming deviant depends on being converted' (p.107).

130. A. Giddens (1979) op.cit. p.198-233 on a theory of historical social change. He argues that previous structural or functional models of social change polarized stability and change thus locating time (i.e. historicity) in the change dynamic conception of society only. This is totally misconceived since time is involved in every conceivable social practice. Thus, revolutionary change is only differentiated from social stability

(re: social continuity over time) in terms of the pace and duration de-routinization and the re-grooving of the new social routines and practices into the altered social system.

131. John H. Marx (1980) 'The Ideological construction of post-modern identity models in contemporary cultural movements', in R. Robertson and B. Holzner (eds) (1980) p.149.

132. B. Taylor (1976) op.cit. p.11.

133. R. Haughton (1978) 'Formation and Transformation' in W. E. Conn (1978) p.23-26.

134. D. A. Snow and R. Machalek (1983) 'The Convert as a Social Type' in R. Collins (ed) 1983 p.259-89.

135. 'Ransford's reasons' (1851) op.cit. p.248.

136. W. H. Holcombe (1866) op.cit. p.4.

137. D. A. Snow and R. Machalek (1983) op.cit. p.269.

138. P. Abrams (1982) 'Historical Sociology'. Open Books Pub. Ltd. Ch. 7 'Explaining Events: a problem of method' p.190-226, esp. 190-201.

139. B. Taylor (1978) op.cit. p.321.

140. W. Shaffir (1978) 'Witnessing as Identity Consolidation' in Hans Mol (ed) (1978) p.39.

141. Dr. Young reporting on Dr. Holland's paper at one of these reading sessions entitled 'An exposition and defence of homeopathic principles with remarks on the value of experience in the treatment of disease' in B.H.S. Minutes and Correspondence Vol. 2 (1850) Nov. 7th p.253 and Dec. 5th p.271.

142. Dr. McGilchrist (1861) 'The correlations of science, philosophy and medicine'.
Brit. Jour. Hom. 19(76) p.177-201.

143. 'Science and Sectarianism' (1868) op.cit. p.428-45.

144. a C. Neidhard (1869) 'Where do we stand? How can we best promote the scientific progress of homeopathy?
Brit. Jour. Hom. 27(110) p.547-74.
b R. Hughes (1882) 'The Scientific claimes of Homeopathy'.
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145. Dr. Jousset (1884) 'Influence of Homeopathy on contemporary science'.
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148. a Dr. Hayle (1860) 'Some remarks on the present state of Homoeopathy'. Brit. Jour. Hom. 18(71) p.92-100.
b 'Progress of Homoeopathy' (Editorial). Brit. Jour. Hom. (1868) 26(105) p.353-68.
c 'Homoeopathy in 1876' (Editorial). Brit. Jour. Hom. (1876) 34(139) p.1-10.

149. a 'Our Hospital System'. Brit. Jour. Hom. (1856) 14(56) p.209-57.
b 'The Medical Act'. Brit. Jour. Hom. (1858) 16(66) p.529-72.
c 'The Pharmacy Act 1868'. Brit. Jour. Hom. (1868) 26(106) p.78-90.

150. a 'Allopathic Journalism and Justice'. Brit. Jour. Hom. (1856) 14(56) p.154-61.
b 'Conversion of the Lancet to Homoeopathy'. Brit. Jour. Hom. (1858) 16(63) p.153-63.
c D. Macrae (1861) op.cit. p.202-16.
d A. C. Pope (1861) op.cit. p.95-106.

151. W. Shaffir (1978) op.cit. p.41-43.

152. See section 6.5. on strategies of resistance.

153. B. L. Hardin and G. Kehrer (1978) 'Identity and Commitment' in H. Mol (ed) (1978) op.cit. p.85.

154. H. R. F. Ebaugh (1979) 'Out of the Cloister: a study of organizational dilemmas'. University of Texas Press p.46.

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156. idem.

157. J. V. Downton (Jnr) (1973) 'Rebel Leadership: commitment and charisma in the revolutionary process'. Free Press p.71-72.

158. D. A. Snow and R. Machalek (1983) op.cit. p.264-66.
In fact, analysis of the talk and reasoning of the convert, they correctly argue, are the basis for the conceptualization and operationalization of the notion of 'radical conversion'.

159. For example see chapter 4, section 4.4.2.

160. a P. L. Berger and T. Luckmann (1871) op.cit. passim.
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163. a P. Abrams (1982) op.cit. p.1-17, 190-298.
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4. Op.cit. p.872.

5. Op.cit. p.878.

6. C. W. Luther (ed) (1848) 'A Concise View of the System of Homoeopathy and refutation of the objections commonly brought against it'. James McGlashan/William S. Orr and Co. for the Irish Homoeopathic Society p.147.

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8. idem.

9. This is not to regard commitments in a negative light but to hold that those commitments are open to critical inspection and rejection, if necessary, by later historians of medicine. The problem is that much of the history of medicine has been founded by professional regular practitioners who have found it impossible to escape the celebration of 'scientific medicine' and the denunciation of anything else, unless they had a 'precursor' function within their view of its development.

10. F. H. Garrison (1917) 'An Introduction to the History of Medicine'. W. B. Sauders, 2nd revised and enlarged edition. This is a veritable store of 'facts' about the development of medicine by means of an all star cast of the heroes and precursors of modern, scientific medicine. Villains like Hahnemann are entered in order to show how unscientific they were. Garrison provides 775 pages of cumulative, linear, 'progressive' history of Euro-American medicine with 46.83% of its pages given over to the 'Modern' period during the 19th and 20th centuries.

11. Op.cit. p.778.

12. Op.cit. p.449.

13. idem.

14. idem.

15. Op.cit. p.190 and 224.

16. Op.cit. p.449 n.2.

17. D. Guthrie (1945) 'A History of Medicine'. Thomas Nelson and Sons Ltd.

18. Op.cit. Chapter 12 p.215-34.

19. Op.cit. p.219.

20. Op.cit. p.220.

21. R. H. Shryock (1948) 'The Development of Modern Medicine'. Victor Gollanz Ltd.

22. Op.cit. p.138-39.

23. Op.cit. Chapter 13.

24. Op.cit. p.138-39.

25. Op.cit. Chapter 13.

26. Chapters 3-5 of this work are relevant here, but also see appendix for comparative statistics at the time.

27. Op.cit. p.139. N.B. In Shryock's chapter 2 he shows Benjamin Rush's medical system to have a monistic pathology. According to Shryock this is a mark of 'unscientific' medicine yet he hardly regards Rush as in the camp of medical sects and other deviants. Instead he is implicitly interpreted as a pre-modern precursor of scientific medicine, thus ignoring the many inherent contradictions created by a positivist model of medical science and its practitioners.

28. L. S. King (1958) 'The Medical World of the Eighteenth Century'. Robert E. Krieger Pub. Co. Inc. (reprinted 1971)

29. Op.cit. p.157.

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31. Op.cit. p.161.

32. Op.cit. p.166.

33. Op.cit. p.186.

34. Op.cit. p.187.

35. ibid.

36. Op.cit. p.191.

37. See chapter 3 section 3.3 and subsections 3.3.1-3.3.4 inclusive.

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40. C. W. Luther (ed) (1848) op.cit. p.24 *f.n.

41. M. Kaufman (1971) op.cit. p.

42. Op.cit. p.62.

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44. Op.cit. p.72.

45. Kaufman's implicit periodization is something like; 1765-1840 for Heroic Medicine, 1830-70 for Clinical-Hospital Medicine and neo-vigorous therapeutics and 1870 onwards Bacteriological Medicine begins to emerge.

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51. Op.cit. p.10.

52. Op.cit. p.18.

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