Pedagogy and the Building of British Psychiatry at the Age of Asylum, 1792–1914

Polina Merkulova

Submitted in accordance with the requirements for the degree of
Doctor of Philosophy

The University of Leeds
School of Philosophy, Religion and History of Science

September 2022

The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

Acknowledgements

My PhD journey has been rocky to say the least: long bouts of illness, a global pandemic and a senseless war my country of origin decided to wage against its neighbour all added to the usual stresses of postgraduate life. Supporting me during these years has been a difficult job and I am deeply grateful to everyone who tried.

It helped that I had the best supervisors in the world Jon Topham and Mike Finn. They are brilliant researchers, patient mentors and wonderful people. Even though I have been told that PhDing is a solitary occupation, my experience has been the opposite. During my studies I enjoyed the benefits of lively academic culture of the Centre for HPS and I am grateful to the HPS staff and my fellow postgraduates for their interest in my research, great discussion and, most of all, sincere friendship. I am especially thankful to Laura Sellers, Caz Avery, Kevin Jones, Alice Murphy and Rachel Garratt for their help with proofreading. I would also like to say thank you to the patient archivists who helped me get through large and often uncatalogued collections and provided tips on reading illegible handwriting, especially Louise Neilson from the Lothian Health Service Archive and Estela Duncan from the Royal College of Physicians of Edinburgh Archive. I am grateful to the Darwin Trust of Edinburgh for funding this project.

I would also say a huge thank you to all my friends who reminded me that there is life outside the university walls: Lawrence Molloy, Joy Robins, Anna Markova, Lisa Kinch, Rhea Eve D'souza, Ksenia Nikishina, Emma Mikheikina, everyone from the Lindy Fridays (especially Robert Shield), from the photography classes (especially Regina Bakhirova) and the ladies of the Crafty Bitches group. I am also eternally grateful to my GP Dr Konstantin Kisil, who made sure that I was well enough to write this thesis.

Most importantly, I would like to thank my amazing husband Stanislav Merkulov who has been there for me every step of the way. There are no words to describe what his support means to me.

Finally, thank you very much to the readers of my blog who cheered me on and kept reminding me why I love the history of medicine so much.

Abstract

This thesis argues that the establishment of psychiatric education played an integral part in shaping British psychiatry as a medical specialism in the long nineteenth century. It identifies five phases in the development of instruction on mental disease during that period: entrepreneurial (1792–1840), clinical (1841–1858), scientific (1859–1875), compulsory (1876–1886) and specialist (1887–1914). Psychiatric education was a part of medical education and shared its main trends; however, there were peculiar characteristics and challenges connected to the peculiarities of medical practice in lunatic asylums. The thesis places education on insanity in the context of three areas of historical research: the history of medical education, the history of psychiatry, and the history of print culture. It draws on a wealth of archival and printed sources which have not previously been examined alongside each other: reports and minutes of professional associations and medical corporations, lecture notes by teachers on mental disease and their students, institutional archives of medical schools and asylums, parliamentary papers, lay and medical periodicals, and psychiatric books and textbooks. The use of this diversity of sources and historiographical approaches allows the thesis to develop a complex and nuanced narrative and to challenge long-held assumptions about psychiatry's place in medicine, the construction of knowledge on mental disease and the position of the lunatic asylum as the sole institution responsible for the development of psychiatry at the time. In their place, the thesis offers an account of nineteenth-century psychiatry as deeply rooted in the general medical context and responsive to changing societal and professional demands.

Table of Contents

List of Figures **3**

List of Abbreviations **4**

Introduction: Teaching Psychiatry in the Age of Asylum **5**

1. Locating the History of Psychiatric Education 7
2. Rethinking the History of Psychiatric Education 14
3. Approaches, Sources and Outline of the Thesis 25

Chapter 1. Entrepreneurial Instruction: The Emergence of Medical Teaching on Insanity, 1792–1840 ..... **37**

Introduction 37
1. Emergence of the Asylum and the Demand for New Knowledge 40
2. Entrepreneurship in Early-Nineteenth-Century Medical Education 51
3. Entrepreneurial Teaching on Mental Diseases: Alexander Morison 62
4. Entrepreneurial Expansion: Further Initiatives to Disseminate Medico-Psychological Knowledge 76
Conclusion 85

Chapter 2. Clinical Teaching: Practical Instruction in the Asylum, 1841–1858 ..... **87**

Introduction 87
1. The Consolidation of a Professional Community: The Association for Medical Officers of Asylums and Hospitals for the Insane and Its Role in Sharing Knowledge 90
2. The Rise of Clinical Teaching 100
3. Clinical Teaching on Mental Diseases: John Conolly 104
4. Standardising Medical Knowledge and Practices: 1858 Medical Act and the First Medico-Psychological Textbook 115
Conclusion 122

Chapter 3. Scientific Training: Defining and Teaching Science-Based Medical Psychology, 1859–1875 ..... **125**

Introduction 125
1. Scientific Medicine and Alienists as Scientific Practitioners 129
2. Defining Scientific Medical Psychology: David Skae and Thomas Laycock 136

3. The Edinburgh Pedagogical Controversy 145
4. Scientific Asylum, Laboratory Research and Proto-Postgraduate Training 155
Conclusion 163

Chapter 4. Compulsory Instruction: Developing Medico–Psychological Curriculum, 1876–1886 166

Introduction 166
1. The Challenges of Developing a Compulsory Medical Curriculum 169
2. The Precarious Position of Asylum Practitioners 180
3. The MPA's Campaign to Include Mental Disease into the Curriculum 186
4. The Determinants of Success 194
Conclusion 205

Chapter 5. Specialist Training: Psychiatry beyond the Undergraduate Curriculum, 1887–1914 208

Introduction 208
1. The CPM: Establishment, Programme and Objectives 210
2. The CPM: Failure or Success? 220
3. The MPA's Conservative Approach to Education 226
4. Openly Specialised Training: Diploma in Psychological Medicine 232
Conclusion 238

Conclusion: Building the Discipline of Psychiatry through Education 240

Bibliography 250

Archives 250
Primary Sources 250
Secondary Sources 258

List of Figures

Fig. 1.1	Attendance at Alexander Morison's lectures (1823–1844)	p. 73
Fig. 1.2.	Occupations of Morison's Lectures' Attendees (1823–1844)	p. 74
Fig. 5.1.	Successful CPM candidates	p. 223
Fig. 5.2.	Number of candidates for mental nursing examination	p. 224
Fig. 5.3.	Rates of success/failure in Mental Nursing Examination	p. 225

List of Abbreviations

AJMS	*Asylum Journal of Mental Science*
AMOAHI	Association for Medical Officers of Asylums and Hospitals for the Insane
BAAS	British Association for the Advancement of Science
BJHS	British Journal for the History of Science
BMA	British Medical Association
BMJ	*British Medical Journal*
CPM	Certificate of Efficiency in Medical Psychology
DNB	*Oxford Dictionary of National Biography [Online]* 2004– 2017. (Oxford University Press)
DPM	Diploma in Psychological Medicine
GMC	General Medical Council
JMS	*Journal of Mental Science*
LSA	License of the Society of Apothecaries
LSM	Leeds School of Medicine
MPA	Medico-Psychological Association
MRCS	Member of the Royal College of Surgeons
PMSA	Provincial Medical and Surgical Association
RCP	Royal College of Physicians
RCPE	Royal College of Physicians of Edinburgh
RCPsych	Royal College of Psychiatrists
RCS	Royal College of Surgeons
UCL	University College London
WRLAMR	*West Riding Lunatic Asylum Medical Reports*
WYAS	West Yorkshire Archive Service

Introduction: Teaching Psychiatry in the Age of Asylum

In 1911 an eminent British psychiatrist Thomas Smith Clouston (1840–1915) reflected on his 50 years in the profession and the "progress of our branch of science" in an article in the *Journal of Mental Science*:

> [The] recent course of psychiatry may be said to have been played in five acts: (1) The teaching of it to students; (2) its taking visible form and voice in the shape of an Association and Journal; (3) its capture of a place in the general profession through the compulsory instruction in its main facts of all medical students; (4) its seizure and utilisation of the laboratory idea: (5) its long struggle for a registrable hall-mark [the Diploma in Psychological Medicine] — now happily attained. Those events have all been intimately related to each other one leading on to the next, and being its necessary corollary.[1]

Later in the same year 71-year-old Clouston was knighted by King George V at Holyrood Palace in Edinburgh, the city where he completed his medical studies and worked for most of his life. During his long career, Clouston served as a superintendent of large Scottish lunatic asylums, conducted empirical studies of mental disorders and their treatments, published several professional and popular books and numerous articles, served as president of various medical associations and was appointed as the University of Edinburgh's first lecturer on mental disease.[2] Presumably, he knew what he was talking about when he distinguished these particular events as key steps in the development of British psychiatry.

Three out of five of these steps are related to the advancements in psychiatric education: teaching psychiatry to students as an extra-curricular subject, the establishment of compulsory instruction on mental disease for all medical students, and the launch of the postgraduate Diploma in Psychological Medicine at the Universities of Manchester, Durham and Edinburgh in 1911. In the context of the existing history of psychiatry this view is highly unorthodox. Clouston did not just highlight the importance of events usually overlooked by historians, he also omitted some of the most notable milestones of the familiar historical narratives: the asylums and asylum reform movement, changes in the lunacy legislation and the abolition of physical restraint. Why did Clouston put such a strong emphasis on education? Was it only his peculiar interest in teaching that led him to construct such a narrative?

---

[1] Clouston 1911: 207.
[2] Beveridge, 1991.

A closer look at primary sources would quickly provide us with a resolute "no". Clouston's opinion was widely shared and occurred frequently in speeches and articles by his contemporaries. For example, a notable psychiatrist Edmund Whitcombe, in his presidential address to the Medico-Psychological Association in 1891, said:

> Nothing, to my mind, marks so distinctly the progress made in Psychological Medicine as the fact that the General Medical Council has, at last, included it in the list of compulsory subjects for education and examination.[3]

Two years later, another President of the Association, J. Murray Lindsay spoke on the same theme in his inaugural address:

> [T]he Medico-Psychological Association […] has progressively advanced […] in proof of which, if any were needed, I would point […] to the successful efforts with regard to the study of mental diseases and clinical teaching of insanity […], a subject now made compulsory and adopted by several teaching and examining bodies.[4]

British psychiatric and medical journals were full of expressions of the vital importance of education for the progress of psychiatry; hence, the lack of interest in the history of psychiatric instruction is a peculiarity of the current historiography and contrasts sharply with the historical actors' views.

In this thesis I will reconstruct the history of British psychiatric education in the long nineteenth century and demonstrate its integral role in shaping psychiatry as a medical specialism. This work will not only address the absence of in-depth research on the subject but offer a new perspective on the history of British psychiatry in the nineteenth century. I will challenge long-held assumptions about psychiatry's place in medicine, construction of knowledge on mental disease and the lunatic asylum as the sole institution responsible for the development of psychiatry at the time. In their place I will offer a more nuanced account of nineteenth-century psychiatry as deeply rooted in the general medical context and responsive to changing societal and professional demands.

Before we move on to the substantive chapters, I will provide a brief overview of the historical context of the topic, explain why an understanding of the development of psychiatric education is crucial for understanding the history of psychiatry since the 1790s and elaborate

[3] Whitcombe 1891: 509.
[4] Lindsay 1893: 473–74.

on the relevant historiographical approaches. In the final section of this introduction, I will describe my methods and sources and provide an outline of the thesis and its main arguments.

1. Locating the History of Psychiatric Education

In the following chapters I will present an account of the development of psychiatric education in Britain between 1792 and 1914. As with many other European histories, the long nineteenth century accommodates this narrative better than the strict limits of a 100-year period. Following the British historian Eric Hobsbawm, credited with coining the term "long nineteenth century," I chose the starting and ending points of the period based on key events which signalled the change of an era, in my case the Era of the Asylum. In 1792 a new kind of institution for the insane was established — the York Retreat, which served as a model for the public asylums in the following century. This has conventionally been seen as the starting point in the creation of asylumdom — the system which adopted institutionalisation as the main response to mental disease in Britain — and while it is possible to trace longer-term continuities, I argue here that it was an important turning point in the development of psychiatric education.[5] The choice of 1914 as the final year of the period was an obvious one: it is the start of the First World War — an event which left few areas of life unscathed. The particular significance of the war for British psychiatry was in the changes in medical understanding of insanity based on the phenomenon of shell shock and the consequent revision of psychiatric treatments. Although asylums did not disappear completely, after the war they stopped being the ultimate answer to treating mental illness and gradually lost their significance. The Era of Asylum had ended, but it left behind an important legacy — an established system of psychiatric education which continued to develop in the following years.

The history of psychiatric education in Britain is located at the intersection of three areas of historical research: the history of medical education, the history of psychiatry, and the history of print culture. All three are equally important. From its inception in the early-nineteenth-century psychiatric education in Britain developed within medical education. Although sometimes teachers on mental diseases allowed lay people to attend their courses, they had never been the target audience. All the courses were intended for medical students, licensed medical practitioners and, from the end of the century, mental nurses. The contents of

[5] See Section 1 of Chapter 1 for further discussion. For different interpretations of the history of the York retreat and its significance see L. Smith 1999a; Digby 1985; Mitchell 2018; Porter 1987; Brown 2011: 82-112; Scull 1993:96-104.

the courses and didactic materials were shaped by the accepted theories of mental illness, practices of dealing with it and lunacy legislation; hence, understanding the history of psychiatry is essential for studying psychiatric education. Finally, many medical practitioners gained their knowledge of psychiatry not by attending courses but by reading the numerous publications on the subject: articles in medical periodicals, lecture outlines and transcripts, textbooks, manuals and treatises. These printed materials were especially important in the first half of the nineteenth century as there were few lecture courses on mental disease and they could not accommodate the growing demand for psychiatric knowledge. At the same time, the asylum system was growing, legislation changing and approaches to insanity multiplying, so even those who completed the lecture courses would have to keep up with new publications to stay up to date in their knowledge of psychiatry. In its turn, a systematic analysis of psychiatric education as a unified subject will shed new light on all three of the research areas.

Let us briefly examine the state of medical education, psychiatry, and print culture between 1792 and 1914, as we know them from the existing scholarship and then move on to a more detailed discussion of the historiography.

During the long nineteenth century British medical education underwent a series of changes and reforms which transformed it from a hodgepodge of apprenticeships, university training, private medical schools, lectures by independent teachers and visiting hospital wards into a system consolidated by a single compulsory curriculum, governed by a national professional body and leading to a registration in a single nationwide medical register.[6] These changes corresponded to the changes in the structure of the medical profession itself. The traditional tripartite division into physicians, surgeons and apothecaries had started to fall apart by the end of the eighteenth century and from its ashes rose a new and more familiar to the modern reader separation between general practitioners and consultants.[7] Another serious transformation was associated with the slow but steady growth of medical specialisation. The British medical profession, decentralised and torn by internal power struggles, largely resisted specialisation seeing it as a threat which might destroy the already weakened professional cohesion.[8] These changes affected psychiatrists as much as all other medical practitioners: they obtained their medical licences according to the existing regulations, strove to gain higher places in the professional hierarchy and negotiated a narrow path between claiming to have special knowledge of mental diseases and avoiding the wrath of the anti-specialist medical

[6] Bonner 1995; Butler 1986.
[7] Loudon 1986; 1995; Peterson 1978.
[8] Weisz 2003; 2006; Casper and Welsh 2016.

elites.

All the major nineteenth-century medical reforms — the Apothecaries Act of 1815, the Medical Act of 1858, and the Medical Act of 1886 — had regulation and improvement of medical education at their heart.[9] Their aim was to improve the social status of medical practitioners and to grant them more authority and professional autonomy. Another important reason to organise medical education better was to use it as an objective criterion to distinguish between regular and irregular practitioners or "quacks" as they were disparagingly called by qualified medics. The public was supposed to take their cue from the official licences when choosing where to seek medical help and appeal to regular practitioners instead of the unlicensed "quacks". The reformers thought that this would kill two birds with one stone: protect the public from incompetent medical advice and reduce the competition for patients between practitioners. Furthermore, establishing a standard of medical education could bring more equality into the ranks of the medical profession and increase the authority of non-elite practitioners, such as GPs or provincial doctors. Finally, a place on the standard curriculum could lend legitimacy to the new or marginalised medical disciplines, such as vaccination, hygiene and psychiatry.

Although none of the acts brought about a complete fulfilment of all those goals, they still helped the medical profession move in the desired direction. The Apothecaries Act of 1815 provided a formal way for British medics to qualify as GPs or apothecary-surgeons and prove their competence in both branches of medical practice.[10] This qualification became the first official step away from the antiquated tripartite hierarchy. The 1858 Medical Act established a single national medical register, a list of officially approved licensing bodies and a single professional organ to govern the medical profession across Britain — the General Medical Council (GMC).[11] One of the important functions of the GMC was to design and enforce a single standard medical curriculum. After 1858 the entrants into British medicine started on a more equal footing, compared to their predecessors, and the discrepancies in training and licensing between different bodies grew increasingly less substantial. The Medical Act of 1886 advanced uniformity amongst medical professionals further. It reinforced the GMC's position and its influence on the medical curriculum, officially allowed women to register as medical practitioners and obliged all practitioners to be trained and examined in all "essential branches"

[9] Roberts 2009; Loudon 1995.
[10] Loudon 1995: 167–71; Holloway 1966; Peterson 1978: 5–39.
[11] Roberts 2009; Bonner 1995: 182-202; Butler 1981: 62–118.

of medical practice: "medicine, surgery and midwifery."[12]

The ideas of what and how medical students should learn to become competent practitioners had also been changing during this period. The first half of the century saw the shift from prioritising book learning and classical "gentlemanly" knowledge to increasing importance of clinical teaching and developing clinical skills.[13] From the early 1860s the emphasis shifted again, this time to scientific and laboratory training. From then on medical practitioners had not only to be skilled at diagnosing and curing disease but also to become "men of science," able to understand and conduct medical research.[14] This development in education allowed for the emergence of a new medical occupation — that of the medical scientist, who did not treat patients but focused on research, teaching and development of new and improved treatments.[15] Many of the medical scientists were particularly interested in the study of the brain and the nervous system and, among other purposes, their findings aimed to inform psychiatric practice.[16] Finally, by the end of the century medical specialisation became more accepted and students had to learn some of the special subjects as part of the compulsory curriculum (including psychiatry from 1886) and there appeared the first specialised postgraduate diplomas, for example, the Diploma in Public Health and the Diploma in Tropical Diseases.[17]

Another area of historical research which is important for understanding the development of psychiatric education is the history of psychiatry. As discussed earlier, the long nineteenth century was the Era of Asylum. In Britain it has usually been seen as starting with the emergence of the asylum reform movement in the 1790s, the foundation of the York Retreat in 1792 and the development of moral treatment as a new way of addressing the mental disease.[18] This was the period when institutionalisation of people suffering from mental illness in large asylums became the most common treatment. At an asylum everything from architecture to pharmaceutical treatments was supposed to have a curative effect on the

---

[12] Roberts 2009: 53.
[13] Bonner 1995; Loudon 1995.
[14] Bonner 1995; Bynum 1994, 2008.
[15] Bynum 1994: 92–118.
[16] Clark 1981; Jacyna 1982; Hunter 1973; Danziger 1982; Quick 2014.
[17] Weisz 2003; 2006.
[18] L. Smith 1999a: 12–52; Scull 1993: 1–114; Shorter 1997: 1–32. Periodisation in the history of psychiatry is clearly contested territory and largely depends on the focus of a particular study. For example, in this thesis I follow the historiographical trend that identifies the opening of the York Retreat as an important turning point in the history of psychiatry. I chose it as a starting point for my time period because it had a significant and lasting effect on the development of psychiatric education in Britain in the nineteenth century (see Chapter 1, Section 1 for a more detailed discussion). On the other hand, throughout the thesis I also point out the longer-term continuities between periods, such as the influence of eighteenth-century ideas and writings about insanity on nineteenth-century psychiatric education and practice.

patients.[19] Removed from the environment where they became insane into the highly regimented wards of the institution, they were supposedly guided towards recovery by the asylum staff, who dictated the patients' diet, dress, occupation, entertainment, and additional medical interventions such as water treatments, application of leeches or drugs. Institutionalisation was a typical Victorian solution for various social problems, not just insanity. In Britain the nineteenth century was characterised by the growing systems of prisons, workhouses, and hospitals.[20] Similarly to asylums these establishments were also envisioned as particularly suited to fulfil specific purposes. In this respect, the lunatic asylums were not all that different from Victorian hospitals, and the approach to the problem of insanity was consistent with how other illnesses were addressed.

The pre-eminence of asylums as the response to insanity was embodied in nineteenth-century lunacy legislation. The 1808 County Asylum Act empowered local magistrates to build tax-supported public asylums to provide free custody and treatment to pauper lunatics.[21] However, this Act did not offer any rules on how the asylums should be governed or standards of patient treatment. The following persistent lobbying by the activists of the asylum reform movement through a series of select committees appeals to the public and scandalous investigations into malpractice in private madhouses led to the passing of the 1845 Lunacy Acts. The Acts made the building of county lunatic asylums compulsory and created the Lunacy Commission, whose task was to inspect public and private asylums and provide more detailed recommendations on improving asylum practices.[22] This legislation did not offer as much guidance for practice as British asylum doctors hoped but over the years the Lunacy Commission's recommendations provided further elaborations on what was considered good practice.[23] Although the criticisms and the campaign for reforming the 1845 Acts started as soon as they were enacted, no major amendments passed until 1890.

Having the asylum as a foundation of British psychiatry in the nineteenth century had significant implications for its development. First of all, as a rule, mental patients were not admitted into the wards of general hospitals; if they were sent for medical treatment, they went to a public asylum if they were poor or to one of the smaller private asylums if their families could pay for their treatment. A small percentage of the insane were cared for at home, some were kept in workhouses, especially in the second half of the century when the asylums grew

[19] L. Smith 1999a; Shorter 1997: 7-22; Scull 1993: 115–68; K. Jones 1991a.
[20] Melling and Forsythe 1999.
[21] L. Smith 1999a: 12–52; Scull 1993: 88.
[22] Scull 1993: 115–75.
[23] K. Jones 1991b.

too overcrowded, and from about mid-century many criminal lunatics were detained in prisons.[24] Secondly, this model of institutionalisation reinforced the divide between mental and all other kinds of patients and catalysed the formation of psychiatry into a separate medical specialism significantly earlier than specialisation was accepted by the majority of the medical community.[25] Finally, all these factors led to a separation of medical practitioners working primarily with insane patients into a distinct group and, to an extent, set them apart from the rest of the medical community: they became special doctors, working with special patients, in special places. Therefore, it may come as no surprise that they were the first group to organise themselves into a professional association based on the "branch of medicine" they practised — the Association for Medical Officers of Asylums and Hospitals for the Insane (AMOAHI) in 1841 — and launched the first specialised medical journal, the *Journal of Psychological Medicine and Mental Pathology*, in 1848.[26]

It is misleading, however, to represent British psychiatrists as isolated from the rest of the medical community and psychiatric knowledge as a prerogative of only a few specialists. Asylum doctors were not only actively engaged in their own association but also took part in regular medical societies and corporations. For example, a well-known alienist John Conolly (1774–1866) was one of the founders of the Provincial Medical and Surgical Association in 1832 (which later became the British Medical Association) and the *British and Foreign Medico-Chirurgical Review* in 1836.[27] Thomas Laycock (1812–1876), a physician with a special interest in insanity and physiology of the nervous system, served as a Professor of the Practice of Physic at the University of Edinburgh from 1855 to 1876 and delivered a course on mental diseases there as an addition to his main job.[28] Thomas Clifford Allbutt (1836–1925) worked as an asylum doctor and a Commissioner of Lunacy but also had a flourishing practice as a general physician, invented the clinical thermometer and was elected president of the British Medical Association.[29] The list could go on: most psychiatrists were members of one of the medical Royal Colleges, the British Medical Association, the GMC and other general medical bodies.

The reverse was also true; general medical practitioners often engaged with psychiatric

[24] For the history of care outside the asylum walls see Bartlett 1999; Bartlett and Wright 1999; Suzuki 2006; L. Smith 2017; Miller 2007; Murphy 2006 for mental illness and Victorian prisons see Cox and Marland 2018a, 2018b; Sellers 2017: 127–69; Kelly 2011; Allderidge 1974.
[25] For specialisation of British medicine see Weisz 2003: 561–74; 2006: 26–44, 164–90; Casper and Welsh 2016.
[26] Renvoize 1991; Scull 1993: 232–33; Oppenheim 1991: 24–25.
[27] Scull et al. 1996: 48–83.
[28] James 1996: 57–61; 240–81.
[29] *DNB.*

knowledge. Large medical periodicals such as the *Lancet* and the *British Medical Journal* frequently published articles, discussions and book reviews on psychiatric topics. The British Medical Association had a dedicated Psychological Section at its annual meetings. Furthermore, the law required two qualified medical practitioners to sign a certificate of insanity for a person to be confined in an asylum. However, the same law made it illegal to sign the certificates for the doctors connected to private asylums or serving as staff in the asylum receiving the certified person.[30] Therefore, most often this task fell to general practitioners. This had serious implications as incorrect diagnosis of insanity followed by confinement in an institution could land the hapless doctor in court.[31] The legal liability was a significant stimulus for medical practitioners to familiarise themselves with at least the basics of current psychiatric knowledge. A growing number of courses on the subject were offered to medical students and qualified practitioners throughout the century and from 1886 instruction on mental disease became compulsory.

This brings us to the third area connected to the history of psychiatric education — nineteenth-century developments in print culture. The beginning of the nineteenth century saw the rise of a new type of periodical literature — the dedicated scientific and medical journal which allowed relatively fast dissemination of professional knowledge and provided platform for discussions on intra-professional matters between practitioners from different parts of Britain.[32] These periodicals did not just contain papers on original research but included transcripts of lectures, reviews and summaries of medical and scientific books, and answers to their readers' questions. Medical journals were commonly used by medical students and practitioners for the purposes of self-education and supplementing their studies at medical schools.[33] From the outset early medical journals contained articles on mental disease and served as a source of information on the subject.

Another important kind of literature which flourished in the nineteenth century and played an important role in spreading psychiatric education were medical textbooks and manuals. They usually were affordable, provided structured, systematic, and accessible information on particular medical subjects and were used in taught courses as well as for self-study.[34] Popular textbooks did not only help to disseminate information but also contributed to

[30] Lunacy Act 1845, 8&9 Vict., c. 100.
[31] McCandless 1981.
[32] Topham 2013, 2016; Dawson et al. 2020; Bynum et al. 1992. The new print formats created a forum for debate quite distinct from older forms of pamphlet exchange, such as that discussed in Andrews et al. 2013 in regard to John Monro and William Battie's dispute in the 1750s.
[33] Frampton 2020a, 2020b; Peterson 1978; Bartrip 1992.
[34] Topham 2000a, 2009, 2013; Richardson 2008: 60–92.

shaping of scientific and medical disciplines.[35] The first psychiatric textbook in Britain was published in 1858 and went a long way towards establishing a consensual core of knowledge on mental diseases at the time.[36]

In addition to these two main types of printed sources which were important for the development of psychiatric education there were other sorts of literature which played a significant role in this story: outlines of lectures, pamphlets, treatises, sensationalised portrayals of psychiatry and psychiatrists in the lay press and so on. As I will discuss in more detail below, most of the existing historical scholarship is focused on the publications of original research on mental disease in periodicals or separate treatises. The examination of the different kinds of psychiatric publications through the lens of their use for educational purposes will enrich both the history of psychiatry and the history of the nineteenth-century medical print culture.

As we have seen, all three areas: medical education, psychiatry, and print culture were undergoing a series of transformations during the long nineteenth century. These changes gradually brought them into a shape more familiar to the modern reader: standardised system of medical education, a medical specialism designated to mental illness and easily recognisable scientific literature aimed at specialists and separated into distinct disciplines. The historical research, which traced the transformation of these areas' separately offers us a detailed explanation of causes and consequences of these changes. The same type of research applied to the development of British psychiatric education will yield similarly illuminating results and provide a new interpretation of the interconnections between social, professional and scientific interests in the shaping of psychiatry and medical education.

2. Rethinking the History of Psychiatric Education

The body of research on the history of psychiatry has been growing steadily from the 1970s. Before then the histories of psychiatry had been typically written by psychiatrists themselves or administrative historians who presented a narrative of progress, humanitarianism and the heroism of early psychiatrists. In Britain this outdated tradition started with *Chapters in the History of the Insane in the British Isles* published by an influential alienist Daniel Hack Tuke in 1882 and continued in the twentieth century in the works of Gregory Zilboorg, Franz G. Alexander, Sheldon T. Selesnick, Aubrey Lewis and Kathleen Jones, just to name a few.[37]

[35] Lungren and Bensaude-Vincent 2000; Bucchi 2008; Cloître and Shinn 1985; Fleck 1979.
[36] Merkulova 2016; Beveridge 1998b.
[37] Zilboorg 1941; Alexander and Selesnick 1966; Lewis 1967; K. Jones 1955.

These "Whiggish" histories were seriously challenged in 1960s by the French philosopher Michel Foucault, who in his book *Madness and Civilisation* presented an alternative historical narrative of the development of psychiatry as a system of surveillance and control.[38] His critical account and the works of other supporters of the anti-psychiatry movement, such as Thomas Szasz, Erving Goffman and R. D. Laing, inspired a new wave of "revisionist" histories.[39] It commenced with Andrew Scull's seminal work *Museums of Madness*, in which he developed the themes raised by Foucault but founded his analysis on a careful study of a wide range of archival documents.

This newly sparked interest in the history of psychiatry and a revisionist attitude led to the publication of a host of original historical research in the 1980s and 1990s by Roy Porter, David Wright, Elaine Showalter, Peter Bartlett, Joseph Melling, Jonathan Andrews, Anne Digby, Michael MacDonald, Leonard Smith, and Janet Oppenheim, as well as further works by Andrew Scull and many others.[40] The revisionist histories did not just challenge the earlier Whiggish narratives written from within psychiatry but shifted the focus of research from medical authorities and psychiatrists to other areas and actors. The new generation of historians tended to write histories of madness, rather than histories of psychiatry. This involved the recovery of patient voices and experiences, the examination of therapeutic settings and practices and the analysis of "mixed economies of care," exploring the roles of different authorities involved in provision for the insane — both medical and lay, religious and legal, public and private, and national and regional.

Although professional historians had come to play the leading role in advancing the history of psychiatry, they did not completely displace psychiatrists interested in the history of their discipline. There was a significant tension between the two groups which led to passionate and sometimes belligerent debates in person and in print. However, the divide between historians and clinicians was not unassailable and there were some productive collaborations. For example, the new *History of Psychiatry* journal, established in 1991, was edited by a psychiatrist German Berrios and a historian Roy Porter. Later the same duo co-edited *A History of Clinical Psychiatry* – a book which examined the history of psychiatric disorders from clinical and socio-historical points of view.[41] A classic three-volume series *The Anatomy of*

[38] Foucault 1995 (first published in English in 1965).
[39] Szasz 1960; Goffman 2017 (first published in 1961); Laing 1990 (first published in 1960).
[40] See, for example, Porter 1987; Wright 1997; Showalter 1987; Bartlett 1999; Forthyte et al. 1999; Melling et al. 1997; Andrews et al. 1997; Digby 1985; MacDonald 1981; L. Smith 1999a, 1999b; Oppenheim 1991; Scull 1993.
[41] Berrios and Porter 1995.

Madness also had a mixed editorial team and included papers authored by both historians and psychiatrists. Another example of productive collaboration is a two-volume work *150 Years of British Psychiatry* that was edited by two psychiatrists, German Berrios and Hugh Freeman, but which contains chapters by prominent revisionist historians such as Roy Porter, William Bynum and Leonard Smith. Furthermore, there are examples which demonstrate that histories written by psychiatrists could be historiographically and methodologically sound, such as the works of Allan Beveridge and Claire Hilton, and revisionist accounts which criticise asylums but still present a narrative of psychiatry's progress, for instance, Edward Shorter's *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*.[42]

The twenty-first century brought further growth and expansion of the field of history of psychiatry and mental health. Building on the early revisionist works and sophisticating historiographical approaches, in the last twenty years historians of psychiatry have created a detailed and nuanced picture of the British lunacy system and of the experiences of people diagnosed with insanity. There has continued to be a strong focus on patient voices and researching individual asylums.[43] In addition to these, there has been more research into the peculiarities of the history of psychiatry in different parts of the UK and Ireland.[44] The legal aspects of insanity and the intersection between mental illness and criminality have also enjoyed significant historians' attention, and so has the role of the Poor Law, local communities and patients' families in the treatment of the insane.[45] There is still marked interest in the history of psychiatric diagnoses, symptoms and nosologies but recent studies tend to employ more complex historiographies combining clinical histories with social and cultural histories and philosophy of psychiatry.[46]

Although there are obvious continuities between the more recent scholarship and the

---

[42] Shorter 1997.

[43] A good example incorporating both trends is Louise Hide's *Gender and Class in English Asylums*, 1890–1914 (2014). On patient voices see also: a recent edited volume by Ellis et al. *Voices in the History of Madness: Personal and Professional Perspectives on Mental Health* (2021); Holland 2021; Brückner 2021; L. Smith 2008; J. Shepherd 2016b; Beveridge and Williams 2002; Beveridge 1998a, Chaney 2015. For examples of recent studies of individual asylums see: Dobbin 2016; Evans et al. 2008; Wallbaum 2019; Eastoe 2020.

[44] For instance, Mauger 2017; Cox 2012; Philo 2004; Murphy 2003; Goad 2020; Philo and Andrew's "Introduction" to the 2017 special issue of the *History of Psychiatry* on the history of psychiatry and insanity in Scotland offers a useful overview of the state of historiography and the papers of the issue further contributed to the existing body of literature.

[45] For some examples of recent literature on these topics see: on legal aspects Moran 2018, 2019; Carson 2018; Takabayashi 2017; Laragy 2013; Kelly 2011; Andrews 2010; C. Smith 2007; Bartlett 2001; Eigen 2010, 2016; Hasson 2010; on the role of Poor Law Farquharson 2016; Ellis 2008, 2006; Miller 2007; on communities, families and treatment outside of the asylums: L. Smith 2017; Wannell 2007; Suzuki 2006; C. Smith 2006; Murphy 2006; Levine-Clark 2000.

[46] See, for example, Jansson 2022; Janssen 2021; K. M. Jones 2019; Millard 2015; Chaney 2013; Scull 2011b; Eigen 2010; Loughran 2008.

works published in the last decades of the twentieth century, in the last twenty-two years the history of British psychiatry has mushroomed into a much larger and more diverse area of research. There is a growing body of literature focusing on gender and class of both patients and medical staff.[47] The history of mental disability and the history of child psychiatry have become distinct areas of research.[48] Our understanding of asylums in nineteenth-century Britain has been enriched by detailed studies of various aspects of institutional life and practices, ranging from built environment and landscaping, through treatments and entertainment, to death, post-mortems and mourning.[49] Archaeological studies of asylums, such as the ones by Susan Piddock and Katherine Fennelly deserve a special mention as they have provided yet another insight into those institutions through the examination of their material culture.[50] There is also a growing interest in the visual culture of psychiatry and medical portraiture which has added a further dimension to our knowledge of the history of insanity and patients' experiences.[51] Alannah Tomkins's research into the cases of medical men admitted as patients to lunatic asylums has introduced even more nuance into our understanding of the relationships between doctors and institutionalised patients.[52] Some historians have focused on asylums as sites of scientific research and knowledge production challenging the view of asylums as "warehouses for the insane".[53] The history of mental nursing is another important aspect which had been largely overlooked but has received due consideration in the past twenty years.[54] Historians have not limited themselves to just the medical story and have published on wider issues related to insanity, such as its public perception, portrayals in popular culture and the political history of madness.[55] The history of colonial psychiatry is another area of research which has blossomed in recent years and has shed light on the issues of race, imperialism and relationships between the local and colonisers'

[47] For example, see Hide 2014; Almond 2020; Peschier 2019; J. Shepherd 2013; Suzuki 2007; Marland 2003, 2004; Levine-Clark 2004; Andrews and Digby 2004.
[48] On mental disability see: Jarrett 2020; Eastoe 2020; Melling and Dale 2006; Wright 2001; Jackson 2000. On child psychiatry see: Champion 2021; Taylor 2014, 2016; Rosenthal 2012; Hutchison 2011; Evans et al. 2008.
[49] See, for example: on built environment: Topp et al. 2007; Fennelly 2014; Franklin 2002; on treatments and entertainment Kearin 2022; Golding 2020, 2021; Daskalova 2021; Topp 2018; Cox et al. 2018; Ellis 2013; Hickman 2009; Cherry and Munting 2005; on death: L. Smith 2012; C. Smith 2011; Andrews 2011; Cullen 2017.
[50] Piddock 2007; Fennelly 2019.
[51] See for example, Sidlauskas 2013; Rawling 2021a, 2021b, 2017, 2011; Bressey 2011; Plessis 2015; Godbey 2000; Kearin 2020; Beveridge 2018.
[52] Tomkins 2012; 2017: 199–231.
[53] See for example, Wallis 2017a, 2017b; Finn 2012; Cullen 2017; Buklijas 2017.
[54] Neuendorf 2019; McCrae and Nolan 2016; Borsay and Dale 2015; McCrae and Wright 2015; McCrae 2014; Monk 2009; T. Dickinson 2015.
[55] For example: Kryssova 2020; Degerman 2019; Sedlmayr 2011; Cross 2010; Melling and Forsythe 2006, Ellis 2020.

traditions of dealing with insanity.[56]

Even from this exceedingly brief survey of literature, we can get a sense of the richness and complexity of the recent historiography of psychiatry and mental illness in the nineteenth-century Britain. However, to date the history of psychiatric education has largely evaded the inquisitive gaze of historians.[57] Through extensive research I identified only a few publications specifically dedicated to the subject. The most well-known of them is John L. Crammer's chapter in *150 Years of British Psychiatry: The Aftermath* which outlines a 200-year-long history (from 1770 to 1970) in just 32 pages.[58] In the paper Crammer pointed to some of the most notable events, publications and historical figures; however, his account is fairly short, lacks precision and does not draw on enough archival sources to substantiate all of his arguments. Aubrey Lewis's "Psychiatric Education: Background and History" (1967) is an even shorter piece, just 10 pages, which covers a period from the mid-eighteenth to the mid-twentieth century. Lewis did not go into a detailed analysis, instead providing a descriptive account seasoned generously by quotations from archival sources. Fredrick Ernest James's piece in the *Psychiatric Bulletin* is less known. It encompasses a period from 1800 to 1971 and is mostly based on materials published in the *Journal of Mental Science* and the MPA minutes, with no reference to educational materials or contents of the courses and examinations.[59] Finally, the latest publication on psychiatric education is Filippo Maria Sposini's 2021 paper on the emergence of psychiatric certification in the second half of the nineteenth century and its relation to the changes in lunacy legislation.[60] Although it is encouraging to see this recent interest in the topic, a journal article is limited in size and scope and there is still a need for a broad and systematic history of psychiatric education in Britain.

By contrast, most leading historians of psychiatry refer to education or the lack thereof frequently and use it as evidence to support their claims. For example, Andrew Scull, when attempting to explain the development of the Scottish school of psychiatry and its strong influence on the rest of Britain referred to the continuous practice of instruction on mental disease in Edinburgh from the mid-eighteenth century as an important factor contributing to

---

[56] See, for example, Raeburn et al. 2022; McCarthy 2012; McCarthy et al. 2017; Mills 2000; Summers 2010; Brunton 2015; Rajpal 2015; Coleborne 2007; Monk 2008; L. Smith 2014; Deacon 2003; Jain 2003.
[57] Research on the history of psychiatric education outside of the British context is also scarce and lacks systematic treatment. For some examples see Kovács 2020; Wübben 2016; Engstrom 2004: 147–173; Goldstein 1987: 120–151; Boschma 2003: 81–112; Weiss 2012. There have not been international or transcultural studies of the history of psychiatric education and there is not yet enough published research to construct large-scale international surveys similar to Bonner's international history of medical education (Bonner 2015).
[58] Crammer 1996.
[59] James 1991.
[60] Sposini 2021.

the flourishing of the school.[61] Janet Oppenheim mentioned the lack of established professional education as one of the reasons for psychiatry's marginalised position within medicine in the first half of the nineteenth century.[62] Louise Hide identified the appearance of systematic teaching of insanity for medical students and the establishment of specialist certificate in medical psychology as signs of the evolution of asylum doctors as a separate professional group, emerging "from a faltering medical lineage of physicians" in the second half of the nineteenth century.[63] The list of examples could go on and on. Historians of psychiatry from different historiographical camps often mention education but take it for granted without drawing clear connections between the issues of training and instruction and other parts of their research.[64] This approach results in claims which seem intuitively right but are hazy on the details. For example, it seems fair to suppose that having a continuous system of training would help building a strong and influential tradition of practice and research. But how? It looks like a fair assumption to say that having a system of professional education is an important step in professionalisation and in securing public trust and respect. But why exactly?

Also, there are biographical writings on famous British alienists which describe their pedagogical work, such as chapters on John Conolly, Alexander Morison, John Charles Bucknill, and Henry Maudsley (all of whom we are going to meet in the following chapters) in *Masters of Bedlam,* the biography of Thomas Laycock by Frederick Ernest James or Michael Barfoot's paper on David Skae.[65] However, it is difficult to understand the significance of famous figures' educational efforts as there is no comprehensive account of the larger context of psychiatric training. The same is true for the existing studies of psychiatric textbooks and other educational materials.[66] Writing on the history of Tuke's *Dictionary* in 1991, William Bynum suggested that the study of psychiatric education and analysis of textbooks and surveys on mental disease was an under-explored and promising direction of research, however it does not seem to have inspired much scholarly enthusiasm.[67]

The dearth of research on psychiatric pedagogy cannot be explained by the insignificance of the subject. From the fragment of Clouston's paper and numerous other mentions of advancements in education as important achievements for the whole discipline we

---

[61] Scull 2011a.
[62] Oppenheim 1991: 16–53.
[63] Hide 2014: 41.
[64] For example, Shorter 1997; Scull 1993; Smith 1999a; Crammer 1994.
[65] Scull et al 1996; James 1996; Barfoot 2009.
[66] Some of the existing literature on psychiatric textbooks and manuals include: Beveridge 1998b, 2018a, 2018b; Bynum 1991; Ion & Beer 2002a, 2002b.
[67] Bynum 1991.

can see that the historical actors found the issues of psychiatric education extremely important. The sheer amount of time and labour that went into improving training on mental disease should be enough to attract historians' curiosity. British psychiatrists put a lot of energy into the fierce discussions of the best way to train doctors and nurses in their subject, the campaign to convince the licensing bodies and the GMC to include psychiatry in the curriculum and the establishment of independent postgraduate certification in medical psychology. Clearly, building a strong and well-functioning system of education was an important direction of nineteenth-century psychiatrists' efforts and the history of psychiatry during that period should reflect this.

This thesis will demonstrate that choosing pedagogy and practices of dissemination of psychiatric knowledge as the focus of research allows us to transform our current understanding of psychiatry in nineteenth-century Britain. This direction of research will shed light on the close connections between psychiatry and general medicine. Contrary to the common assumption, psychiatry was not completely isolated from the rest of the medical profession or universally shunned and despised. The situation was more nuanced and relied on a host of factors: the complexities of professional politics, issues of stigmatisation and prejudice, the state bureaucracy and so on. The interplay between these factors will become visible when we look at the unique position of British psychiatry through the lens of education, as it involved detailed negotiations between various authorities and stakeholders. It will also help us in revising the received understanding of the second half of the nineteenth century as a time of stagnation, despair and disillusionment for psychiatry. It will become clear that, even though at the time no significant breakthroughs in psychiatric treatments appeared, valuable advancements were made in establishing an infrastructure of training and sharing knowledge on mental disease. This infrastructure made possible the impressive achievements of British psychiatry in the twentieth century — such as the adoption of Kraepelinian approach, creating out-patient mental health services, and the advancement of psychodynamic theories and practices — even though they often depended on engagement with new psychiatric theories and approaches emanating from continental Europe.[68]

Education and training make medical practitioners. Therefore, this is where we should look for answers as to what was considered good practice at the time, what knowledge and which skills were deemed necessary and what rules of conduct the medical practitioners were

[68] Although the scope of this thesis is limited to Britain, throughout the thesis I will explore the influence of foreign medical education and psychiatric ideas on British pedagogy, most notably French and German.

expected to follow. Unlike professional treatises and research papers, textbooks and lecture courses attempt to provide a systematic, cohesive and non-controversial overview of a subject. These types of communication contain clearly spelled out professional norms and expectations for the students and often outline how the newly acquired knowledge could be profitably used. Since textbooks and printed lectures presume little or no special knowledge on the part of the reader, they often state even the most obvious principles, which would not appear on the pages of more advanced literature. This is invaluable historical material. It offers insights into the ways psychiatric research and practice was explained to students and became ingrained in the minds of newcomers into medical profession. If we want to know how and why medical practitioners approached mental illness in certain ways, then understanding their starting points is key.

If the study of the history of psychiatric education is so important, why then has there been so little research on this topic so far? The answer to this question lies within the current historiographical approaches to both the history of psychiatry and the history of medicine and medical education.

In general, history of psychiatry developed as its own discipline, separate from the history of medicine. Current historiography emphasises the outsider status of psychiatry within the nineteenth-century British medical establishment and focuses on the aspects that set it apart from other areas of medicine. The main reason for this is the importance of the asylum as the birthplace of modern psychiatry. The shadow of the grand institutions for lunatics looms so large that it obscures many other possible avenues of exploration. It is a trend that started with the self-congratulatory administrative histories which celebrated Victorian public asylums as precursors to the twentieth-century welfare system.[69] The situation continued when sociologically informed historians produced their revisionist histories of asylums as "museums of madness", a vivid metaphor coined by Andrew Scull in his early work.[70] It did not matter which side of the debate a particular historian supported, they mainly focused on the asylum, its merits, horrors, functions and modes of operation.

With the growing numbers of researchers and publications the focus of the history of psychiatry expanded but still to a large extent continued to revolve around the asylums. There are studies of asylum patients' experiences, in-depth explorations of particular institutions, researches into treatments, medications, diagnoses, recreation and legislation governing the

[69] For example, K. Jones 1955; Alexander & Seleznick 1966; Zilboorg 1941.
[70] Scull 1979. Other examples include Rothman 1971; Scull 1981, 1993; Shortt 1986.

work of asylums.[71] Even studies of nosologies and their development are often based on the asylum admissions records.[72] This is not to say that this voluminous and constantly growing body of research is unimportant; on the contrary, the asylum was the defining factor of the development of British psychiatry in the nineteenth century and it deserves the historical attention it has received. This thesis likewise did not avoid the irresistible pull of the asylum, as is clear from its title: "Pedagogy and the Building of British Psychiatry *in the Age of Asylum"*.

The danger of narrowly focusing on institutions for the insane is that, if left unrecognised, that focus inevitably leads to the emphasis on the separation of psychiatry from the rest of medicine. As mentioned earlier, establishing lunatic asylums as the main locations for psychiatric practice stimulated the early consolidation of psychiatry into a distinct medical specialism. Asylums were the main factor that distinguished psychiatry from other areas of medicine, and mental patients from all other types of patients. Therefore, historical research which focuses on asylums also focuses on what made psychiatry different from other medical disciplines. It does not help the situation that historians who decide to look away from the asylums also usually wish to look beyond the medical story and aim their attention at the non-medical aspects of insanity, such as economics and the Poor Law, local and national politics, family and community involvement, popular culture and fiction, and so on. Inadvertently, these studies also contribute to a view of psychiatry as disconnected from medicine.

This image of psychiatry as separate, marginalised and even despised by other medical practitioners is reinforced by asylum doctors' incessant laments about the lack of respect and recognition within the wider professional community. If considered out of the more general context of nineteenth-century medicine, these complaints seem to support the assumption that psychiatry was in fact "medicine's poor cousin".[73] However, a look at a wider range of sources would reveal that medical practitioners of all sorts accused their colleagues and the lay public of not affording them enough respect. Furthermore, the resolute resistance of British medical elites to specialisation within medicine created a professional climate in which all emerging medical specialisms were often publicly disparaged and devalued, so that psychiatry was in

[71] For example, see: for asylum patients' studies Berkenkotter 2008; Ellis et al. 2021; Beveridge 1998a; Andrews 1998; Rawling 2021a; Chaney 2015; Plessis 2021; L. Smith 2008; for particular institutions: Eastoe 2020; Finn 2012; Wright 2001; Walton 1981; Digby 1985; MacKenzie 1992; for treatments, medications and diagnoses: Scull 2011b; Oppenheim 1991; Marland 2003, Cox et al. 2018; Jansson 2013, 2022; Janssen 2021; Shepherd and Wright 2002; for recreation and patient management: Ellis 2013; Hide 2014; Golding 2020; Hickman 2009; Cherry and Munting 2005; for legal issues: K. Jones 1991a, 1991b; R. Smith 1991; Bartlett 2001; Farquharson 2016; C. Smith 2007; Firsythe et al. 1999; Moran 2018.
[72] See for example K. M. Jones 2019, Berrios 1996; Berrios and Porter 1995.
[73] Turner 1991.

good company. Otorhinolaryngologists, neurologists, ophthalmologists, venereologists and so on were in the same boat.[74] Even in cases when entrepreneurial doctors managed to attract funding and open specialist hospitals, they did not gain recognition for their specialism from the medical elites and had to struggle for the inclusion of their disciplines into the medical curriculum. In fact, psychiatry was one of the first specialised subjects to achieve that goal.

Another factor that points to a closer than commonly acknowledged connection between general medicine and psychiatry is the large number of articles on psychiatry-related topics in medical periodicals. All the nineteenth-century medical journals frequently printed materials on insanity, its diagnosis and treatment; the medical press covered the lunacy law reforms and the *Lancet* even ran its own investigations into asylum practice; books on insanity were advertised and reviewed in the medical press and the print runs suggest that those books' readership was larger than the relatively small community of psychiatrists.

Why is attention to the connections between psychiatry and the rest of medicine so important for the study of the history of psychiatric education? First of all, because it is as much a part of the story of British medical education as it is of the history of psychiatry. It is impossible to study it only from the perspective of the latter. Secondly, a large proportion of psychiatric teaching happened outside the walls of the asylums. It took place in medical schools, universities, hired rooms, and under the auspices of medical corporations. Moreover, not all teachers of psychiatry were asylum doctors or even considered themselves specialists in mental disease. These considerations are important to conceive appropriate research questions and to locate the relevant archival sources: many of the necessary materials on psychiatric education are not held at asylum archives but kept in the archives of universities and medical corporations.

Considering the above, we might expect medical historians to be the ones to write the history of psychiatric education. However, the authors of many large-scale studies on medical education, professionalisation of medicine and the development of medical specialisms often choose one of two strategies: they either ignore the characteristics of psychiatry that distinguish it from other areas of medicine or completely exclude psychiatry from their analyses. The works of M. Jeanne Peterson, George Weisz and Tomas Bonner exemplify the former approach.[75] They talk of asylums as examples of special hospitals, psychiatric associations as instances of specialised medical associations, and professorships and lectureships in mental

[74] Weisz 2003; 2006.
[75] Peterson 1978; Weisz 2003, 2006; Bonner 1995.

disease as being like any other specialised medical teaching posts. Although this is fair in broad terms, it masks the unique circumstances of the development of psychiatry as a distinct specialism and hides the need for a more focused study of education on mental disease. John C. Burnham's book on the historiography of medical professionalisation is an emblematic example of the second approach. From the outset the author stated that he would not "deal with special cases, particularly those generated by psychiatry" and referred the readers to the already existing separate "long history" of the psychiatric profession.[76] This attitude returns us back to the self-contained history of psychiatry, detached from medicine as a whole. A study of instruction on mental disease requires a view of psychiatry as both distinct *and* connected, but existing histories usually chose one or the other.

Another explanation for why the history of psychiatric education has escaped the attention of researchers is that most scholarship prioritises the process of knowledge production over the process of its communication. Hence, historians are more likely to investigate the development of new psychiatric knowledge and practices, rather than the processes of their dissemination. Thus, there are many excellent studies on Victorian research concerning the functions and structure of the nervous system, mental diseases and various approaches to their treatment and prevention.[77] However, little is written about how and why some of them became popular among British psychiatrists and where the newcomers to the profession learned about them. This situation is similar to an example historian James Secord provided in his seminal paper "Knowledge in Transit."[78] There he looked at the scholarship on Michael Faraday and pointed out that, although a lot was written on Faraday's work and its importance there was no clear explanation of how it became widely known and respected. Secord wrote:

> Readers are led to picture a Faraday who was supremely good not only at things that might justify his title of genius (such as experimental skill and conceptual innovation) but also at things he was unable to do—such as making his name known to everyone in the land or traveling instantaneously between continents.[79]

The same is true of leading British psychiatrists of the nineteenth-century. We are aware of the influence of well-known individuals like A. W. F. Browne, Thomas Laycock, Thomas Clouston, James Crichton-Browne, Henry Maudsley, and Charles Mercier on the theory and

[76] Burnham 1998: 10.
[77] For example, Jacyna 1982, 2000; Jacyna and Clarke 1987; Danziger 1982; Grob 1998; Quick 2014; Casper 2014; Wallis 2017b; Buklijas 2017.
[78] Secord 2004.
[79] Ibid: 663.

practice of psychiatry in Britain. We also know that they inspired many a young medical practitioner. However, our understanding of the exact mechanisms of how this came about is hazy at best.

Secord's solution for the problem is to place practices of knowledge communication at the centre of historical inquiry by removing the boundary between producing new knowledge and its circulation. This approach provides opportunities for the type of research carried out in this thesis: constructing a history located at the intersection of several disciplines. By focusing on the practice of communication of psychiatric knowledge to students and beginner-practitioners — education — it is possible to transcend the boundaries between the history of psychiatry, history of medicine and history of nineteenth-century print culture. The Knowledge-in-Transit approach also allows exploration of international communication and its influence on psychiatric pedagogy in Britain.

Another advantage of adopting such a historiographical approach is that it helps to highlight the role of teaching and didactic materials in shaping the discipline of psychiatry and creating consensual knowledge. There are numerous recent studies which explore these functions of pedagogy and textbooks in sciences.[80] However, this avenue is explored less within the history of medicine and psychiatry. There is a growing body of research into particular materials used in medical education such as textbooks, atlases, illustrations and museum specimens.[81] The recent rise of scholarly interest in the visual culture of medicine and psychiatry also touches on the uses of images for the purposes of communication and pedagogy.[82] This thesis will contribute to developing this focus on the role of pedagogical materials, exposing their importance for the making of British psychiatry.

3. Approaches, Sources and Outline of the Thesis

The main goal of this thesis is to construct a general framework for the history of psychiatric education in Britain in the long nineteenth century. This approach is relatively unusual for the recent historiography of psychiatry. Unlike most of the recent studies it is broad both in its geographical and temporal scope. This will inevitably lead to the loss of historical details and fine distinctions between regions, institutions and individual cases. This is a

[80] Such as Simon 2011; Kaiser 2005; Lundgren and Bensaude-Vincent 2000; Gooday 1990, 1991a, 1991b, 2005; Topham 2000a, 2009, 2013.
[81] For example, Richardson 2008; Reinarz 2005; Kemp 1993; Berkowitz 2012; Whiteley 2017, Bates 2008; Palfreyman and Rabier 2017; Kusukawa 2012.
[82] For example, Rawling 2017, 2021b; Berkovitz 2012; Kemp 1993; Jordanova 1993; Jackson 1995; Kusukawa 2012; Richarson 2018; Palfreyman and Rabier 2017; Gilman 1988.

conscious sacrifice in favour of the opportunity to create a general overview identifying the large-scale systems, structures and trends of the nineteenth-century history of psychiatric education. However, even a broad project must have limitations; hence this study is limited to Britain. Although broadening the geographical scope and creating international and trans-national accounts of psychiatric pedagogy would allow for a more complex analysis of the movement of ideas, people and practices, the current scarcity of research on the topic make it impossible to achieve it within the scope of this project. Nevertheless, I briefly explore international connections at various points in the thesis where they are necessary to understand British developments.

In my work I heed Andrew Scull's caution against artificially narrowing the focus of historical research lest we find ourselves immersed in a "constricted vision that flattens and distorts our sense of perspective, and leaves in obscurity aspects of historical reality that acquire meaning only when placed in a larger contextual frame."[83] James Secord expressed a similar concern regarding the history of science warning historians that "an emphasis on the local contexts of science can lead to parochial antiquarianism. […] We think we are making grand epistemological conquests, when in fact we are studying a few practitioners of a relatively esoteric activity, whose wider importance is assumed rather than demonstrated".[84] This is not to claim that studies with a tighter focus which elaborate, correct and confront general accounts are insignificant; on the contrary, such works continue to be necessary and essential for the development of the field. However, in the case of the current history of British psychiatric education a narrow research scope cannot yield desirable results because there is no larger contextual frame to inform a more detailed vision.

Sposini's paper is a vivid example of how quickly an attempt to investigate just one aspect of psychiatric training in Britain can become confused and riddled with misinterpretations due to the lack of understanding of a more general context.[85] Furthermore, as Secord pointed out, "[t]he more local and specific knowledge becomes, the harder it is to see how it travels."[86] The existing studies of individual asylums, regions and significant figures offer a fragmented picture of the nineteenth-century psychiatry with unclear connections between various actors and locales and uncertain links to other medical and lay structures. Sometimes these connections and the spread of knowledge is assumed by researchers; for

[83] Scull 1999: 298.
[84] Secord 2004: 659.
[85] Sposini 2021.
[86] Secord 2004: 660.

example, Jennifer Wallis, in her undoubtably excellent study of the investigation of the body at the West Riding Lunatic Asylum, suggested that her findings reflected the practices of the Victorian asylum in general.[87] This might be accurate; however, the study of the communication of the knowledge and practices of the West Riding doctors would significantly strengthen this claim and uncover the networks and architecture of medical knowledge about insanity during this period. Which brings us back to the importance of broader histories and large-scale models which allow for tracing the way knowledge travels.

On the other hand, to be truly useful a general account must be rooted in sufficient archival research to avoid unfounded speculation. In my work I drew on a variety of primary sources which have not yet been examined alongside each other. First, I studied the reports and minutes of professional bodies involved in establishing medico-psychological education — in particular, the MPA, the GMC and the Royal College of Physician of London. Secondly, I looked at the archives of medical schools and asylums which provided instruction on mental disease such as the Leeds Medical School, the West Riding Lunatic Asylum, the University of Edinburgh Medical School, the Royal Edinburgh Asylum and the York Retreat. Thirdly, I examined relevant parliamentary records — for example, the reports of multiple select committees on medical education and on provisions for lunatics, asylum reform and lunacy legislation. Fourthly, I explored personal papers of key individuals — for instance, Alexander Morison, Thomas Laycock and Daniel Hack Tuke. Finally, a large part of my research was focused on published materials such as articles in general and medical periodicals; treatises, textbooks, and manuals on medical psychology; printed outlines and summaries of lectures; and pamphlets.

Having expected to struggle with finding relevant material at the start of this project, I was surprised and delighted by the richness and variety of archival sources I encountered. The lecture notes by teachers of medical psychology and students who attended their courses did not just show the content of the courses but often suggested reactions elicited by certain parts of the lectures: what was the most important, what was surprising and what was frequently overlooked. Recorded minutes from the meetings of the various professional bodies and the disputes taking place in the correspondence sections of medical journals as well as the evidence from the select committees provided a thorough and complex account of discussions surrounding training on mental disease. Personal papers, such as diaries and letters, were full

[87] See the Introduction to *Investigating the Body in the Victorian Asylum: Doctors, Patients, and Practices* by J. Wallis (2017), especially p. 16.

of practical details and illuminated the intricate networks of medical practitioners and the relationships between various persons and groups. The ever-increasing amount of digitised published sources available online allowed me to work with a range of materials inaccessible to earlier historians. Many of those sources have also been made searchable, which allowed me to locate a wide range of relevant articles and passages. The unexpected breadth of sources meant that instead of arduous labour searching for scarce archival material I was confronted by the opposite problem — the overwhelming amount of often uncatalogued sources available to me.

The format of this thesis is an answer to this challenge of abundance. To prevent each chapter growing into a thesis of its own I settled on the approach of presenting the main trends and major developments of the period and focusing on just a couple of examples to discuss these large-scale tendencies in more detail. Of course, in each period there was considerable diversity in educational activities on mental disease. Some teachers stuck to earlier pedagogy while some experimented and innovated their teaching. Similarly, although I discuss aspects of the visual culture of medico-psychological education in my analysis, I could not make it a particular focus of my study, not least because much of the relevant material, such as the materials exhibited and passed around in teaching rooms, would need to be pieced together from different archives and studied within particular teaching contexts. Furthermore, many medical practitioners who worked with mental patients were self-taught, especially until the 1880s. There was a host of textbooks on medical psychology published in the second half of the century which presented a variety of approaches both to the understanding of mental diseases and to communicating relevant information to the readers. Many of these textbooks were not widely read but still had their own admirers, even if their numbers seemed insignificant.[88] All these smaller accomplishments and deviations from the main course of development of British psychiatric education deserve further investigation, but in this thesis I deliberately restricted my scope to discovering and presenting the big picture using large brushstrokes which could be filled in and corrected by future research.

[88] For example, some of the texts on mental illness remained popular and widely read for a long period of time, whereas others were relatively quickly forgotten and superseded by newer literature. In the thesis I discuss the key texts during their heyday; however, a further examination of the reasons for the longevity of psychiatric publications is one of the more exciting directions for future research. As Aileen Fyfe has demonstrated, the reasons some nineteenth-century texts remained widely read for a long period of time depended on a complex set of factors, including the qualities of the original text and the actions of publishers and editors in keeping the text relevant to new generations of readers (Fyfe 2002). This is true for psychiatric literature, as is evident from the few existing studies on the subject — for instance, Bynum 1991; Ion and Beer 2002; D. Weiner 1991, 2000; Merkulova 2016. Ruth Richardson's seminal work on the making of *Gray's Anatomy* (2008) also offers an insight into the factors contributing to the longevity of medical texts.

This approach meant that I had to choose the sources and case studies to be featured more prominently. To do this, I developed a set of criteria. First, the cases had to illuminate the innovations in psychiatric pedagogy which became widespread and widely accepted as good educational practices. Secondly, they had to have significant influence on contemporary psychiatric practice and training. To assess this criterion, I examined the number of students taking the course or examination, the availability of alternatives, the responses of lay and professional communities in the medical and popular press, discussions at the meetings of professional bodies, references of other psychiatric teachers and recollections of students who have attended the course. Finally, each case study had to be well-documented to allow detailed analysis. An inadvertent side effect of my selection was that the institutions and individuals I have chosen were the same ones who featured prominently in earlier hagiographical writings on the history of psychiatry and are generally well-known. No marginalised or unexpected practitioners made it into my selection precisely because they had less power and opportunity to influence large-scale educational trends and the contemporary hierarchies of power. Moreover, the fact that the contributions of such figures as Alexander Morrison, John Conolly, David Skae, Tomas Laycock, James Crichton-Browne and Henry Maudsley were considered important by their contemporaries and early historians ensured that their personal archives were well-preserved.[89] I hope that future research aimed at revising and improving this account of the history of psychiatric education will uncover new and less-known figures, practices and institutions.

In this thesis I aimed to answer three core questions: *what*, *where* and *how* did British medical practitioners learn about mental disease in the long nineteenth century? To do so, I examined who taught psychiatry during this period, the reasons why they decided to do that and the arguments they used to attract students to their courses or readers to their publications. I also analysed their pedagogical methods, the contents of the courses and how both of these changed over the period between 1792 and 1914. Since psychiatric education was a contested ground between the psychiatric community, mostly represented by the members of the Medico-Psychological Association, and the general medical establishment, represented by the licensing bodies and the GMC, I investigated the relationships between these authorities and how their

[89] This choice of historical actors is not meant to valorise these people or to suggest that they were especially good, or kind, or more intelligent than their colleagues, nor that their voices are historically more important than the voices of their patients, students, other asylum employees, concerned lay people or other people involved in the giant nineteenth-century lunacy system. The works of the abovementioned revisionist historians challenged early representations of psychiatrists as humanitarian heroes several decades ago and offered much more complex and problematic accounts of them. See, for example, Scull et al. 1996; Andrews 1997; Barfoot 2009; Andrews et al. 1997; L. Smith 1999a, 2020; Porter 1987; Suzuki 1995.

relationships were affected by external factors such as changes in the medical labour market, patient advocacy, sensational press coverage and the growing authority of science in Victorian society.

By this point, a reader familiar with the recent historiographical trends in the history of psychiatry will have noticed the conspicuous absence of detailed discussion of the educational experiences of ordinary students and asylum practitioners, or of patient voices, in the way I have approached this work. This choice was also dictated by the aims and methodology of this study. In general, both individual patients and students did not have sufficient power to influence the macro-developments in psychiatric education that are the main subject of this thesis. Furthermore, the study of patient voices and individual experiences requires a markedly different research methodology: it necessitates focus on fine details and variations. As Louise Hide noted, such an approach "inevitably limits the time period" and the number of institutions under consideration.[90] In her *Gender and Class in English Asylums*, Hide focused on two large lunatic asylums and a period of just 24 years.[91] Focus on one or two institutions, limiting the time period to a couple of decades and choosing a subgroup of patients to investigate are all typical methodological techniques for this kind of research.[92] However, my thesis employs the opposite approach: it covers over a hundred years and the whole of the Great Britain. As explained above, this approach is better suited to the aims of the study but the framework of the history of psychiatric education constructed in this work will help future researchers to locate patient voices and the lived experiences of various historical actors.

Up until now I have been using the term "psychiatry" to denote the area of medicine concerned with the study, treatment and prevention of mental illness; however, I will rarely mention it in the body of the thesis. The reason for this is that the word "psychiatry" was not widely adopted by British practitioners until the early twentieth century. Instead, I will opt for the terminology more commonly used by the historical actors. As with many other aspects of nineteenth-century medicine there was no clear consensus on what to call the branch of medicine dealing with mental disease. There existed terms like "mental science", "mental physiology" and "psychological medicine," but the most commonly used term, which was unobjectionable to the majority of historical actors throughout the period, was "medical psychology". From 1865 it was adopted by the British psychiatrists' professional body — the

[90] Hide 2014: 3.
[91] Ibid.
[92] For example: Holland 2021; Chaney 2015; L. Smith 2008; Beveridge 1998; Shepherd 2016a.

Medico-Psychological Association (MPA).[93] So, "medical psychology" is the main term I will use throughout the thesis, and synonyms will sometimes be employed, when citing particular actors or sources.

There was even more variation when it came to naming practitioners of medical psychology. Primary sources are full of terms such as "alienist", "medico-psychologist", "psychiater", "psychiatric physician", "asylum medical officer" and "asylum physician." Some of these were used interchangeably but they are not full synonyms. For example, some referred specifically to those who worked in asylums (for instance, "asylum physician") whereas others were more general (such as "alienist"). From the 1860s the MPA broadened its membership requirements and started accepting all qualified medical practitioners with a special interest in medical psychology.[94] This is the most accurate description for the whole group of practitioners I will discuss in my thesis; however, I will use several terms according to the precise context and the historical actors' self-identification. For example, depending on the situation, I will speak of "members of the MPA", "asylum practitioners/officers", "alienists" or "medico-psychologists".

Finally, the terminology for mental health problems also developed and changed throughout the period under consideration. The term "madness" was prevalent at the beginning of the nineteenth century but was superseded by "insanity" (more popular in medical contexts) and "lunacy" (more frequently used in legal contexts) until these faded slowly to be replaced by "mental illness". However, all of the above were sometimes employed by different historical actors during the same time period. In education and published materials terms like "mental disease" and "mental disorder" appeared frequently. For example, the majority of courses in medical schools were called "courses on mental disease/s" similar to other specialist courses named according to the particular medical problems they were targeting. Hence, with this terminology I will also take the cue from the specific context and the actor's lexicon.

In this thesis I argue that the history of education in medical psychology is a part of the wider history of medical education, and that it consequently shared the same general development trajectory in the nineteenth century, with a growing emphasis on clinical education combined with rigorous certification, underpinning a new professional identity, a growing concern for scientific medicine, and a developing tension surrounding the issue of

[93] *JMS*, 11 (1865): 396–97.
[94] Ibid.

specialist training. But the special character of medical psychology as an area of medicine focused on mental rather than physical illness, governed by special lunacy legislation and dealing with patients who were at best considered incapable of being responsible for their own affairs and at worst dangerous to themselves and people around them imposed additional challenges to establishing a system of education on mental disease. First of all, the sites of medico-psychological practice were removed from the usual sites of medical practice: from the beginning of the nineteenth century most mental patients were institutionalised in asylums, and were therefore not treated at home or in general hospitals. This led to peculiarities of establishing clinical training, as the students had to visit an asylum in addition to their attendance in a teaching hospital. There were also serious difficulties in establishing a consensual body of knowledge about medical psychology, which was not strictly necessary for practice and research but was vital for creating a consistent system of instruction across the country. Furthermore, medical psychology struggled to prove that it was a proper scientific discipline and not just speculation and metaphysics. Finally, given that medico-psychological practice was distinct from the rest of medicine by its location, legislation and type of patients, there was a controversy about whether all medical students had to study it or was it enough that training was available to those who were especially interested in the subject.

The main body of the thesis is divided into five chapters arranged in chronological order. Each one is dedicated to a period characterised by a specific trend in medico-psychological education. Identifying five phases in the history of medico-psychological education in this way helps to clarify some of the large-scale changes over the course of more than a century. In my research I identified the following five phases between 1792 and 1914 and dedicated a chapter to each of them: entrepreneurial (1792–1840), clinical (1841–1858), scientific (1859–1875), compulsory (1876–1886), and specialist (1887–1914). However, as with any historical periodisation, this one is an artificial analytical tool. Throughout the thesis I acknowledge the continuities between the different sub-periods and between the periods before and after the one analysed in the thesis. Nevertheless, focusing on the discontinuities allows me to trace pedagogical innovations and major trends in the communication of psychiatric knowledge. For each period I will provide an account of the main educational developments, their context and the factors affecting changes in pedagogy, and a detailed analysis of one or two particular courses or programmes which best represent the characteristic features of the period.

In Chapter 1 I argue that education on medical psychology in the period between 1792 and 1841 was mostly entrepreneurial. The establishment of rate-supported public asylums and

heightened public scrutiny of practices in private madhouses and subscription asylums led to a rise in demand for new knowledge about mental diseases, their diagnosis and treatment. Since there was no centralised system of medical education and no compulsory medical curriculum at the time, it fell to entrepreneurial medical teachers to answer the demand for new medical knowledge. In this chapter I demonstrate that the first such entrepreneurial course on mental disease in Britain was established by Alexander Morison. I also argue that during this period many medical students and practitioners learned about insanity from numerous publications on the subject: printed lectures; literature on organising and running a lunatic asylum; medical books and journal articles on mental disease and their treatment; and fringe literature, most notably, phrenological and mesmerist.

Chapter 2 moves us to the next period, from 1841 to 1858, which was characterised by the emphasis on clinical teaching both in general medicine and in medical psychology. I argue that the alienists actively participated in the larger movement of the British medical practitioners to professionalise and establish unified standards of practice and education. The alienists took part in the establishment and activities of the Provincial Medical and Surgical Association (which later became the British Medical Association) and engaged in the debates surrounding the attempts to bring about medical reform which led to the passing of the Medical Act of 1858. I demonstrate that the asylum medical practitioners adopted many of the same strategies and approaches in professionalising their own area of practice. They started a professional organisation — the Association for Medical Officers of Asylums and Hospitals for the Insane (1841) — and a periodical — the *Asylum Journal of Mental Science* (1853). The alienists were also striving to improve and standardise education in their branch of medicine. Hence, they adopted the pedagogical approach considered the most effective by the medical establishments at the time — clinical instruction. Another important development again came in a form of publication: the British first textbook on insanity was published in 1858. It made medico-psychological knowledge more accessible to newcomers to the discipline by comprehensive, structured and systematic presentation of the consensual foundations of contemporary medical psychology. At the same time, it demonstrated to wider professional and lay publics that medical psychology was a cohesive discipline with its own standards, body of knowledge and a specific skill set. Therefore, it required practitioners to undergo training and instruction before they would be able to competently work with the insane.

Chapter 3 is dedicated to the period between 1859 and 1875, when both general medical education and medico-psychological instruction began to prioritise scientific learning. In this chapter I argue that, although the British medico-psychological community agreed that their

discipline should be grounded in science and that scientific research into mental diseases would bring advancements in their treatment and prevention, the alienists did not see eye to eye on what constituted scientific medical psychology. While a plurality of views was common in nineteenth-century medicine and generally did not create serious problems for practice and research, it became a serious obstacle when it came to teaching. Students needed to learn "textbook science" — consistent, noncontroversial, standardised and accessible for beginners. Hence, the teachers had to work out what "textbook science" was. In this chapter I trace the debates surrounding the issue of teaching scientific medical psychology and compare two vividly different approaches to teaching which coexisted in Edinburgh during this period: the courses by Thomas Laycock and David Skae. I also argue that out of these debates grew an approach that became dominant in later years, which involved laboratory training as the hallmark of scientific pedagogy and the distinction between the needs of undergraduate students who required a brief and practical introduction to the subject and the needs of recently qualified practitioners who were particularly interested in mental or nervous disorders and demanded a deeper knowledge of the subject and guidance in their own research. The pioneer of this hybrid approach, James Crichton-Brown, implemented both programmes in the West Riding Lunatic Asylum in Wakefield, where he was the superintendent, in collaboration with the Leeds School of Medicine.

Chapter 4 focuses on the period between 1876 and 1886 and builds on one of the strands from the previous chapter — the efforts to establish compulsory introductory education on mental diseases for all medical students. I argue that, even though by the 1870s there existed a standard curriculum recommended by the GMC, inserting a medico-psychological course into that curriculum was far from a straightforward task. There was significant resistance to introducing specialised subjects into the compulsory curriculum. The eventual success of the MPA's campaign relied on a unique combination of factors. On the one hand, the MPA members presented convincing arguments in favour of their cause which helped them gain the support of the two leading medical journals, the *Lancet* and the *British Medical Journal,* and of the British Medical Association, Royal College of Physicians of Edinburgh, University of London, two Irish universities, the Faculty of Physicians and Surgeons of Glasgow and the Irish Branch Council. Having alienists amongst the members of the Select Committee on medical education in 1878–79 and of the GMC further assisted the establishment of a compulsory course on mental diseases. However, the factors which pushed the campaign over the finish line were less predictable.

In the early 1880s, the efforts to change lunacy legislation brought the attention of the

Parliament and the public to the issues of education of medical practitioners on insanity. The generational changes in the membership of the GMC and medical elites made them less resistant to specialisation. Finally, an important factor leading to the GMC putting mental disease on the list of recommended subjects was the rise of the sensational "new journalism" which seized the stories of unlawful confinement, abuses in asylums and insanity pleas in lurid court cases as exciting subject matter for newspaper articles. The journalists ridiculed medical witnesses who could not agree on their assessment of the accused's soundness of mind and publicly questioned overall medical authority and expertise. This called for action from the medical establishment which would repair the profession's reputation. Introducing a compulsory medico-psychological course was such an action. It was meant to blame the shameful performances in the courts on the lack of knowledge on the part of individual practitioners and to ensure that such situations would not recur in the future, as all medical practitioners would be appropriately trained.

The final chapter brings us to the other strand of the development of education on mental disease — the establishment of specialised postgraduate training in the period between 1886 and 1914. Here I will argue that teaching on mental disease was affected by major developments in medical education: the professionalisation of medical teaching, growing importance of university education and increasing specialisation. Although the MPA achieved inclusion of medical psychology into the compulsory curriculum it had no control over how it would be taught, as this was in the hands of the teaching institutions. In 1886, to gain a degree of control over training of the new generations of alienists and to prove the ability of the MPA to design a programme of instruction and examination on their specialism, the Association introduced their own postgraduate qualification — the Certificate of Efficiency in Medical Psychology (CPM). In this chapter I demonstrate that the CPM was not a success and that it failed because it did not adequately address the educational needs of medical practitioners and did not take advantage of the emerging trends in medical pedagogy at the time. The certificate's failure was especially striking when compared to the rapid success of another of the MPA's qualifications — the Certificate in Mental Nursing. The MPA during this period was a deeply conservative organisation and it took its members a long time to identify the faults of the CPM and to agree on establishing a new more progressive programme of postgraduate training — the Diploma in Psychological Medicine (DPM). In designing this new scheme, the MPA addressed the issues which led to the CPM's failure and launched the programme in 1911. It ran in collaboration with universities and led to the reception of a non-academic postgraduate qualification.

By providing a first overview of the different phases of medico-psychological education in nineteenth-century Britain, the thesis begins to restore to historical visibility an aspect of the history of psychiatry that practitioners such as Thomas Clouston took very seriously, but which has been largely overlooked by historians. In particular, it demonstrates how the foundations of the asylum system created the demand for new knowledge on mental disease, highlights the issues involved in the development of compulsory medico-psychological training of medical students, throws light on the problems of teaching psychiatry as a scientific subject and provides an account of the emergence of specialist training in medical psychology. While this is inevitably an exploratory history, it opens up important new perspectives on the building of Victorian psychiatry and important new avenues for future research.

Chapter 1. Entrepreneurial Instruction: The Emergence of Medical Teaching on Insanity, 1792–1840

Introduction

In the "Proposal to Establish Lectureship on Diseases of the Mind" which Scottish physician Alexander Morison (1799–1866) sent to his prospective patrons, he argued that:

> Not only is the knowledge of them [diseases of the mind] absolutely necessary to the Practitioner engaged in the treatment of Diseases of the Mind, it is no less so to those who give Certificates of the mental condition of their Patients; and it is much to be wished, that the signs of approaching Insanity, might be well understood by every medical student, since he may not only […] prevent suicide, […] but by early attention to the incipient stage of Insanity he may sometimes be enabled to arrest its further progress.[1]

Morison's appeal was successful in many respects and at the end of 1823 he delivered the proposed course of lectures — the first of its kind in Britain.

In the existing literature on the history of psychiatry the period between the 1790s and 1840s is dominated by the discussion of the establishment of the nineteenth-century asylum system, the process of "medicalisation" of insanity and changes in the legal, social and medical attitudes to mental illness which accompanied it.[2] From the end of the eighteenth century a number of people concerned with the fate of lunatics organised themselves in what is commonly called "the asylum reform movement" in the historical literature. The establishment of the celebrated York Retreat — a new type of institution for the care and treatment of the insane — was an important milestone in this movement.[3] It proposed a new more humane approach to dealing with mental patients named "moral treatment." In 1813 Samuel Tuke (1784–1857), a prominent figure among the reformers, published a seminal work — *Description of the Retreat* — which laid out the principles on which the institution operated. Both the book and the Retreat had a significant influence on the arrangement of provisions for

---

[1] Morison, A., "Proposal to Establish Lectureship on Diseases of the Mind", RCPE, SOC/8/1/2 6:6 Hereafter: *Morison's Proposal.*

[2] See for example: L. Smith 1999a, 2020; Knowles and Trowbridge 2015; Scull 1993, 1981; Shorter 1997; Brown 2006; Porter and Wright 2003; Melling and Forsythe 1999.

[3] Digby 1983; L. Smith 1999a: 12-51; Brown 2011: 82–112.

the insane in the first half of the nineteenth century.[4] It is, therefore, significant that from the first pages of this work the author brings the reader's attention to the importance of communicating expert information for the advancement of treatment and cure of mental disease. Tuke argued that, if "persons engaged in the management of the insane" published more of their observations and experiences of treating lunatics, it would be easier to identify the causes of insanity and "to infer the most probable means of rescuing, or relieving the unhappy victims of this disease."[5] However, very little has been written about how the knowledge about insanity was communicated among the people engaged in its treatment and management. In this chapter I aim to situate the development of medical education on insanity within the larger historical context of the lunacy reform, changes to the medical profession and training and the developments in British print culture.

In his account of the early asylums Leonard Smith persuasively argued that the first public institutions for the insane were experimental: finding new and better ways to alleviate and cure insanity as well as to contain and manage the inmates was a part of the superintendent's job.[6] Furthermore, the reformers called for specific changes to the established ways of treating insanity: at first just for kinder and more humane treatment, and after 1813 for the adoption of "moral treatment" in the newly established institutions.[7] Medical practitioners had to accurately diagnose insanity and played an important if not always a leading role in the running of public asylums, therefore they had to learn the new practices and approaches. Hence, some form of instruction of medical men on mental disease was an intrinsic part of the establishment of the asylum system.

At the same time as the asylum reform movement was gaining momentum, the British medical profession as a whole was undergoing a series of important changes. An active campaign to reform British medicine started in 1793 and at the centre of its agenda were the improvements to medical education and licensing.[8] In the eighteenth century, medical practice was largely unregulated. People desiring to obtain a medical qualification could do so through one or more of the sixteen licensing bodies. Those qualifications varied in the level of difficulty, required lengths and modes of study and rigorousness of testing the candidates' knowledge. There was no set curriculum and most medical students created their own course

[4] L. Smith 1999a: 38–39; Brown 2011: 82–112.
[5] S. Tuke 1813: vii–viii.
[6] L. Smith 1999a.
[7] L. Smith 1999a: 12–51; Scull 1993: 87–104, 132–55; Brown 2011: 82–112.
[8] Holloway 1966; Cowen 1969; Peterson 1978: 5-39; Loudon 1986, 1995; Brown 2009: 1368–69; Graham 2021: 767–70.

of education which consisted of attending lectures at medical schools or universities, walking the hospital wards, learning anatomy at private anatomy schools, completing apprenticeships and taking various extra-mural classes. In the end, the competency and quality of knowledge of the entrants into the profession varied dramatically.[9]

The Apothecaries Act of 1815 was supposed to address these issues and bring some regularity into the profession, but it did not fully achieve its goals.[10] Post-1815 medical education in Britain still largely relied on the entrepreneurial initiative of individual medical teachers and the diligence and good will of medical students.[11]

The demand for new knowledge created by the asylum reform and the founding of public asylums was not easy to satisfy within the chaos of British medical education. There was no way to introduce teaching on mental disease into the curriculum in a centralised manner, and the task of anticipating and meeting this demand consequently fell to the entrepreneurial medical teachers, writers and publishers. They did not miss that opportunity. Starting with Alexander Morison's courses in Edinburgh and in London, lectures on insanity started to appear across the country, medical practitioners and students attended phrenological lectures which often touched on mental disease, and teachers on the theory and practice of physic often dedicated some lectures to mental problems. In addition to these classes, medical practitioners interested in the subject had a range of published sources at their disposal: treatises, journal articles, transcripts of lectures delivered in Britain and abroad and chapters on insanity in textbooks on forensic medicine.

In the first half of this chapter, I will outline the wider historical context of the emerging education on insanity. Section 1 will demonstrate how the establishment of subscription asylums and the emergence of public lunatic asylums created the demand for new knowledge about mental disease and its treatment. My account will clearly show that the emergence of education on insanity was an intrinsic aspect of the rise of modern psychiatry from the early nineteenth century onwards.

In Section 2 I will summarise the most pertinent characteristics of early-nineteenth-century medical education in Britain. I will explain how heavily it relied on the entrepreneurship of ambitious medical teachers and how their initiative was especially important in the areas where conservative academic systems were too slow to adapt to

[9] Loudon 1986, 1995; Rosner 1991; Lawrence 1996, 1988; Bonner 1995: 103–57.
[10] Holloway 1966.
[11] Lawrence 1996, 1988; Bonner 1995: 114–22, 132–35.

innovations. Teaching on mental diseases was one such innovation and, therefore, it emerged as private lecture courses and published materials.

The second half of the chapter is dedicated specifically to the means of acquiring knowledge about mental diseases available to medical practitioners and students between 1792 and 1841. Section 3 will offer a close look at the courses of lectures on insanity organised by Alexander Morison in Edinburgh and London. His teaching epitomised the attitudes to insanity and the common characteristics of medical pedagogy during the period. It was entrepreneurial, independent of existing educational institutions, relied financially on patronage, subscriptions and student fees, did not lead to an official qualification and, although the course was aimed at medical practitioners and students, it was also open to lay people.

Finally, Section 4 will consider other ways of disseminating professional information about insanity in Britain during this period. There I will demonstrate that, although in-person instruction on mental disease was still a rarity, there was an expansion in published sources of information on the subject. The demand for knowledge on insanity stimulated entrepreneurial publishers of medical books and periodicals to release materials on the topic. There were several types of such literature: outlines and reprints of lectures; descriptions of all aspects of running a lunatic asylum; books and journal articles on theories, classifications and particular forms of insanity and heterodox literature, most notably, phrenological.

1. Emergence of the Asylum and the Demand for New Knowledge

Nineteenth-century public asylum system grew out of the philanthropic voluntarism and entrepreneurship of wealthy eighteenth-century individuals. The process started with the invention of a new type of charitable institution — a subscription hospital. It was funded by annual subscriptions and one-time donations and provided free medical care to the poor. Major subscribers influenced the management of the hospitals and could nominate patients. At the time this model was considered highly successful and a sign of social progress.[12]

Soon after the subscription model was adopted for other more specialised medical facilities, such as lunatic asylums. The first one of them, the St. Luke's Hospital in London, opened in 1751, followed by similar institutions in Newcastle, Manchester and York in the 1760s and 1770s. These were not just based on the hospital model but were often affiliated with local voluntary hospitals and located on the same grounds. However, there was an important difference between the subscription hospitals and asylums: the asylums were not

[12] L. Smith 1999a: 12–20, 1999b; Brown 2009.

completely free for the patients. The governors tried to keep the fees low, but these still were only affordable to non-pauper lunatics. Moreover, this led the institutions into financial peril, so most of them started accepting more well-off patients and using their higher fees to subsidise the upkeep of the poor patients.[13] However, there were not many takers, as wealthier families preferred to send their insane relatives to private madhouses. These were run for profit and promised discretion but, also, were unaffordable to the lower classes and infamous for patient mistreatment.[14]

By the end of the eighteenth century several individuals concerned with the faults of private madhouses and aware of the financial struggles of the subscription asylums coalesced into the asylum reform movement. They argued that there was a need for new state-supported and state-regulated institutions for the insane. An important part of the reformers' strategy was, as Scull put it, "the construction of a particular version of the past, one which portrayed the treatment of the mad in Georgian England uniformly in the darkest of hues" to demonstrate the cruelty and inefficiency of existing provisions for the insane.[15]

Until the 1828 Madhouse Act, the proprietors of private establishments for the mad operated under very few legal restrictions. The Madhouse Act of 1774 ordered compulsory licensing and visitation of madhouses by the commission from the Royal College of Physicians in the metropolitan area and by the local magistrates in the counties. Although this sounded good in theory, the Act was not effective in practice because the visitors' powers were significantly restricted. They could not refuse or revoke a madhouse licence, nor could they include in their minutes anything "which tends to impeach the character of any house."[16] All critical comments and suggestions had to be signed by at least three of the commissioners present at the inspection of the madhouse and were kept in a register at the Royal College of Physicians and shown to the public on request. The Act did not contain any clear regulations on the conduct of the establishment or medical care; hence, the commissioners could not point to precise violations. Nor could they release improperly detained inmates, as this had to be done through the court.[17]

This lack of regulation and accountability led to a striking disparity between private madhouses. They contained different numbers of patients, had different staff-to-patients ratios

[13] L. Smith 1999a: 12–51.
[14] Parry-Jones 1972; MacKenzie 1992; L. Smith 2020; 1999b.
[15] Scull 1993: 47.
[16] Madhouses Act 1774, 14 George 3, c. 49: section 15.
[17] L. Smith 2020: 89–134, 1999b; Scull 1993: 24–25.

and offered different treatments. Patients' living conditions also varied dramatically.[18] Characteristically, the reformers were most keen to bring attention to the worst establishments to demonstrate the urgency of the proposed reform and the need of the insane for the state's protection.

The reformers argued that, since the private madhouses were run for profit, their proprietors were primarily attracted to the trade by its money-making opportunities rather than by the desire to alleviate the suffering of the insane.[19] The evidence of this was readily available when one inspected the madhouses for paupers. These were the sites of the most horrific abuses. Since the profit from a single pauper patient was almost negligible, such madhouses were large, understaffed and poorly managed. There were too few attendants to successfully manage the patients and, therefore, staff heavily relied on chains and other restraints to keep their charges in check. The wards were often unglazed and shockingly dirty, the patients kept naked.[20]

Doubtlessly, this situation had to be exposed. However, in the first decade of the nineteenth century the reformers chose not to draw attention to the fact that the same happened at some of the charitable subscription asylums. On the contrary, the evidence published by the 1807 Select Committee stated that the subscription asylums in York, Liverpool, Manchester, Exeter, Hereford, Norwich and Lester were a "great success" and suggested that the planned rate-supported asylums should be merged with the private subscription ones where the latter existed.[21]

The reformers also emphasised that, apart from private madhouses and few subscription asylums, lunatics had nowhere to go and many of them, especially those who posed danger to themselves or others, could not be kept at home. Such people were confined in "Gaols, Houses of Correction, Poor Houses and Houses of Industry".[22] The lunatics left under the care of their families did not necessarily fair better. In his testimony to the 1807 Select Committee Sir George Paul, an aficionado of county asylums, recounted following examples from his inspections of the lunatics kept by the parish outside of poorhouses:

> I have seen poor Lunatics not in the poor house, who have been fastened to the leg of a table within

[18] L. Smith 2020: 239–73.
[19] Duncan 1808; Scull 1993: 80–82; L. Smith 2020: 239–73.
[20] *Report from the Committee on Madhouses in England,* House of Commons, Session 1814–15; 4: 801–46. Hereafter: *Select Committee Report 1814–15*.
[21] *Report from the Select Committee Appointed to Enquire into the State of Lunatic,* House of Commons, Session 1807, 2: 75.
Hereafter: *Select Committee Report 1807.*
[22] *Select Committee Report 1807*: 79.

> a dwelling house; others chained to a post in an out-house; and in one instance I witnessed the case of a man shut up chained in an uninhabited ruin, and food daily brought to him from his relations, living at a quarter of a mile distance.[23]

Moreover, the custody of lunatics outside special institutions could not be done with desired efficiency. Criminal lunatics in prisons required hiring extra keepers or paying other inmates for looking after the lunatics. There was no medical treatment of their condition and, therefore, there was little chance of recovery. According to the asylum reform advocates, establishing large properly regulated county pauper asylums would allow for providing the insane with necessary care and custody at the lowest price and for the shortest period of time as all the cured patients would soon be able to return to work. For example, Paul's provisional calculations showed that "the individual cost of each patient will diminish in proportion as numbers increase to a certain extent; that the most economical establishment would be from 250 to 300 [inmates]."[24]

The reformers' efforts resulted in the 1808 County Asylum Act which empowered county magistrates to build rate-supported asylums for pauper lunatics. However, the Act was permissive rather than prescriptive. Hence, it fell to the entrepreneurial reformers to promote the establishment of the new institutions in their counties. Unsurprisingly, the first public asylums were erected in the counties where there had already been significant effort to organise subscription asylums. The subscribers cooperated with the magistrates and created joint institutions.[25]

Unfortunately, the 1808 Act did not contain clear instructions on the building and management of the new institutions because it was based on the recommendations of the 1807 Select Committee, which did not inquire into the situation deeply and called few witnesses. The Act ordered that the asylums should be located in "an airy and healthy situation, with a good supply of water, and which may afford the probability of the vicinity of constant medical assistance."[26] Apart from this and detailed procedures of funding, admissions and discharges of patients, the Act left the organisation of the asylums to the county justices.

Although the 1808 Act endowed the local magistracy with new powers and an opportunity to increase their authority, relatively few of them chose to open a rate-supported asylum for pauper lunatics. By 1825 only eight institutions had been opened: in

[23] Ibid: 89.
[24] Ibid: 89.
[25] L. Smith 1999a: 12–51.
[26] County Asylums Act 1808, 48 George 3, c. 96.

Nottinghamshire and Bedfordshire in 1812, Norfolk in 1814, Lancashire in 1816, Staffordshire and West Riding of Yorkshire in 1818, Cornwall in 1820 and Gloucestershire in 1823.[27]

The reformers continued their campaign for further changes. They called for stricter regulations of private madhouses, compulsory establishment of rate-supported asylums in all counties and more humane and curative treatment of the insane. There were two important events which advanced the reformers' demands: the founding of the York Retreat and the investigation into abuses at subscription asylums.

The Retreat provided a better model for public lunatic asylums than the deeply flawed subscription institutions. It was founded by the Quakers on the initiative of William Tuke — a prosperous tea merchant — after a Quaker patient died at the York Asylum (a private subscription institution).[28] Wishing to create better provisions for the lunatics in their religious community, the Quakers established their own institution in 1792.[29] There they pioneered a new curative regimen for the insane — moral treatment. It was based on the principles of "kindness" and reinforcement of rational behaviour. The former referred to acknowledging the humanity of the insane patients, care about their comfort and avoiding restraint or coercion except when all else failed. The reinforcement of rational behaviour happened through discipline, work and organised leisure activities. These were aimed at breaking the "bad habits" of insanity and reaffirming sane behaviour. Although the superintendents of the Retreat did not denounce fear as a useful tool to enforce good behaviour, they proposed that "desire for esteem" was a more productive instrument for motivating rational behaviour of the patients.[30]

Everything at the Retreat was organised to support moral treatment. Even the building was purpose-built unlike most of the first subscription asylums and madhouses. As the author at the *Monthly Review* put it:

> … the Retreat seems to possess a decided advantage over every other public receptacle for the insane, in the very great attention that has been paid to the ease and comfort of the patients, to the

[27] L. Smith 1999a: 26–27.
[28] The York Retreat has attracted significant scholarly attention over the years. Whereas some accounts highlight the establishment of the Retreat as a turning point in the history of psychiatry (for example, Foucault 1995; Digby 1985; Scull 1993), others emphasize the continuities between the eighteenth- and nineteenth-century approaches to madness (for example, L. Smith 1999a, 2020; Porter 1987). Moreover, there are works which, although they acknowledge the importance of the Retreat, draw attention to other important changes which took place at the same time. For example, Michael Brown draws attention to the changes in the foundations of medical authority and how this process affected the care for the insane at the change of the century (Brown 2006, 2011). Finally, there is recent scholarship which calls for re-evaluation of the practices at the Retreat in light of the peculiarities of Quacker spirituality (Mitchell 2018). In this thesis I am particularly interested in the role of the York Retreat in the reformers' rhetoric and in promoting education on insanity.
[29] S. Tuke 1813.
[30] Digby 1985: 33–56; Brown 2011: 93; L. Smith 1999a: 187–226; S. Tuke 1813: 84–117.

> removal of all unnecessary restraints, and to the external aspect of the establishment, which conveys no idea of the gloomy purpose to which it is appropriated.[31]

Although it was founded in 1792 the Retreat became widely known only in 1813 after Samuel Tuke, the grandson of the founder William Tuke, published his *Description of the Retreat*. The book was favourably reviewed in several influential periodicals such as the *Critical Review, Monthly Review* and *Edinburgh Review.* The latter called the Quaker institution "the best managed asylum for the insane that has yet been established" and the *Critical Review* expressed the hope "that institutions similar to the present will be established in other places."[32]

Soon the reformers started using the Retreat as an example of their ideals' practical realisation.[33] They were especially keen on promoting the system of moral treatment. Its alleged success served to prove that in competent hands management of the insane rarely demanded coercion or cruelty. According to Tuke's description, the staff at the Retreat were instructed to show kindness to the patients and take into account their feelings. As a result, the patients felt a "kind disposition" towards their keepers which was more effective than chains and, crucially, more effective as a cure:

> at the Retreat, coercion, when requisite, is considered as a necessary evil; that is, it is thought abstractedly to have a tendency to retard the cure, by opposing the influence of the moral remedies employed.[34]

Samuel Tuke hypothesised that the widespread use of restraints and coercion in other institutions could be explained by either incorrect understanding of insanity and the insane, disregard for the patients' comfort or the situation when the earlier cruel treatment deteriorated the relationship between the inmates and the keepers so that restraint was the only tool left at the latter's disposal.[35] Whatever the cause, the need for excessive restraint was always created by the incompetence of the asylum's staff not by the nature of madness as was claimed in the previous century.

This brings us to the second cluster of events which figured prominently in the asylum reformers' rhetoric. If the Retreat represented the positive model, new investigations into the practices of some older subscription asylums and the evidence gathered by the 1815 and 1827

---

[31] *Monthly Review,* 73 (1814): 330.
[32] *Edinburgh Review,* 23 (1814): 197; *Critical Review*, 4 (1813): 97.
[33] Scull 1993: 110; Brown 2011: 91–93.
[34] S. Tuke 1813: 105.
[35] Ibid: 106.

Select Committees helped to paint a clear picture of the "enemy"— the antiquated inhumane madhouse practices.

The committees' inquiries showed how widespread the maltreatment and neglect of lunatics were in all types of institutions. However, this time, the reformers drew special attention to the investigations at two most prominent charitable institutions for lunatics: the York Asylum and the Bethlem Hospital. Both institutions were praised in the 1807 Select Committee Report, but the investigation in 1813–15 revealed a very different picture. In both institutions patients were chained to their beds, sometimes for days and in some cases even for years at a time. Perhaps one of the most publicised cases was that of James (William) Norris at Bethlem who was restrained by a metal harness fixed to a pole near his bed for over a decade.[36] The situation at the York Asylum was not any better. While paying an unexpected visit to the asylum a Yorkshire magistrate Godfrey Higgins found hidden cells for pauper lunatics, which had not been opened during previous inspections. He demanded to look inside and found extreme filth, squalor, stench and complete absence of light.[37] It was alleged that the fire of 1814 which destroyed the asylum's records and killed four of its patients was deliberately set by the staff to prevent further unveiling of abuses.[38] Nevertheless, even without those records the evidence collected by the reformers was overwhelming.

The parliamentary inquiry did not end there. It revealed that all over the country in madhouses, jails and poorhouses pauper lunatics were neglected, beaten, chained, starved and otherwise abused by their keepers. A Quaker philanthropist Edward Wakefield, responsible for exposing the dire situation in Bethlem, visited some private madhouses and in most cases found a similar situation: he was not allowed to visit some of the patients because it was the day they were not allowed to get out of their beds, and most of the ones he was allowed to see were lying on straw pallets, often chained to the wall, sometimes in absolute darkness.[39]

The 1815 Select Committee investigation was significantly deeper and more detailed that the one in 1807. The Commissioners called 41 witnesses, including 15 medical practitioners. They heard from different actors, allowed those accused of maltreatment in their institutions to explain themselves, and examined a large amount of data from different institutions and different parts of the country. The demands of the reformers became clearer too. They asked for the establishment of a publicly funded and overseen system of asylums for

[36] Porter 1987: 124; Andrews and Scull 2001: 274; *Select Committee Report 1814–15:* 822.
[37] Brown 2006: 445, 2011: 95.
[38] Scull 1993: 116.
[39] *Select Committee Report 1814-15:* 826–35.

pauper lunatics which would be run on principles similar to the York Retreat and the few existing public asylums. The patients at such institutions should be treated humanely, moral treatment must be employed, and restraint had to be limited to the necessary minimum. The private establishments and the lunatics confined in their homes were to be regularly inspected by impartial visitors empowered to revoke or refuse licences. Crucially, one of the recommendations of the 1815 Select Committee was to remedy

> [t]he want of medical assistance, as applied to the malady for which the persons are confined; a point worthy of the most serious attention, as the practice very generally is to confine medical aid to corporeal complaints; which circumstance the Committee are the more desirous of inforcing [sic] on The House, as an opinion has been given, by a respectable Physician and another person of great experience, that where the mental faculties are only partially affected (stated by them to be so in seven eighths of the cases,) medical assistance is of the highest importance.[40]

The public asylums envisioned by the Commissioners and the reformers alike were not just places of confinement but medical cure. Importantly, the arguments for conducting treatment of lunatics on "humane principles" and preventing abuse and neglect did not just appeal to the tender hearts of the public but also to their good business sense. As Dr George Button from the Gloucester Asylum put it:

> The exercise of the purest and most enlightened humanity, is not merely eventually the most economical, but also the most effectual means which can be resorted to, to ameliorate the condition of mankind, whether sane or insane.[41]

The reformers' work had not been finished after the 1815 and 1827 Select Committees. Although they managed to get a few minor Acts through the Parliament (most importantly, the 1828 County Asylum Act and Madhouses Act),[42] their demand for establishing a rate-supported pauper lunatic asylum in each county and creating a commission of visors empowered to influence the asylum practices was only fulfilled by the 1845 Lunacy and County Asylum Acts.[43] However, it would be a mistake to conceptualise the legislation of 1845 as a sudden break with the barbaric and cruel practices of the previous century. On the contrary, the slow but steady changes in asylum management, clinical understanding of insanity and

[40] *Select Committee Report 1814–15*: 804.
[41] *Gloucester Asylum Annual Report* (1825) cit. from L. Smith 1999a: 191.
[42] County Asylums Act 1828, 9 George 4, c.40; Madhouses Act 1828, 9 George 4, c. 41.
[43] Lunacy Act 1845, 8&9 Vict., c. 100; County Asylums Act 1845, 8&9 Vict., c. 126.

medical training on mental disease between the 1790s and 1840s made the reform possible.

The *longue durée* history of dealing with madness could be understood through the cyclical changing of the relative importance of the values of "custody" and "cure."[44] The former characterises the focus on restricting the freedom of the insane, isolating them from the rest of the society and protecting the sane majority of the population from the dangerous behaviour of the mad. The latter represents the emphasis on the wellbeing of the mentally ill and the struggle to cure them of their affliction. Within this paradigm the early nineteenth century could be seen as a period with the growing emphasis on "cure."[45]

We can see it stated clearly in the 1807 Select Committee report which suggested erecting county asylums as the "most adequate [measure] to ensure the proper care and management of these unfortunate persons [pauper lunatics], and the most likely to conduce to their perfect cure".[46] If left without appropriate treatment there would be "no probability of their cure, and they [would] remain a burden upon the public as long as they live".[47] The 1815 Committee added that there needed to be medical assistance with the mental illness itself, not just physical infirmities suffered by the institutionalised lunatics. Even Samuel Tuke, who generally maintained that medical treatment alone was of no great use, conceded, in the words of a reviewer, that

> where an insane person happens to be diseased in body, as well as mind, medicine in not only of as great importance to him as to any other person, but much greater; for the diseases of the body are commonly found to aggravate those of the mind.[48]

Importantly, Tuke and other supporters of the moral treatment, who were sceptical of the effectiveness of merely medical interventions, still asserted that asylums were sites of curing mental disease not just custody.

In *Cure, Comfort and Safe Custody* Leonard Smith argued that "the group of lunatic asylums set up in the aftermath of the 1808 Act laid the foundation for the English asylum system" and that "the early asylums were much more the reflection of the local endeavour than their later successor institutions."[49] Building on his account I claim that the establishment and peculiar characteristics of the early public asylums in part shaped the initiatives to educate

---

[44] L. Smith 1999a: 2–3; Digby 1983.
[45] L. Smith 1999a; Digby 1983.
[46] *Select Committee Report 1807*: 74.
[47] Ibid.
[48] *Edinburgh Review,* 23 (1814): 196.
[49] L. Smith 1999a: 8.

medical practitioners on mental disease during this period.

The first public asylums were forged by local initiative rather than centralised effort, so there was great heterogeneity among them. In the absence of accepted standards and proven treatments the governors and staff of the new institutions often had to find their way by trial and error. To prepare for their duties the superintendents of early asylums either went to observe the practices at the already established asylums or corresponded with other asylum practitioners and even madhouse doctors.[50] In 1813 Tuke claimed that several persons who were about to become superintendents of new asylums were living in York and learning about the everyday life of the Retreat.[51] He also stated that allowing such observation was beneficial both for improving the practices at other institutions and for the higher sense of accountability of the asylum staff:

> Though the patients are never exhibited to gratify the curiosity of visiters [sic], yet professional persons, or those peculiarly interested in the subject, are permitted at all seasonable hours, to visit every part of the establishment. It would be well if this plan were generally adopted in other institutions of the same nature, as the uncertainty of visiters [sic] arriving would be some check upon neglect, or improper conduct.[52]

Although it was clear to most that the old attitudes and treatments were not acceptable anymore, the new tradition had yet to be created. In that sense the first public asylums were highly experimental.[53] These experiments aimed to discover best practices which would effectively cure the lunatics and keep them safe and contained during treatment. The success of the enterprise relied heavily on sharing the results of endeavours at different institutions. There was the demand for knowledge from the medical practitioners involved in treatment of the insane and from the interested public actors who wanted to see proof that the new institutions could fulfil the promise of curing their charges.

Evidently, medical practitioners played an important role in the new curative asylums. Andrew Scull and other sociologically informed historians describe this time as a period of medicalisation of madness and the establishment of medical hegemony over it.[54] However, it was only a part of the dynamic relationship between the medical professionals and laity in the early asylums. The opinions of medical men, especially physicians, carried significant weight

---

[50] Scull 1993: 88–89.
[51] S. Tuke 1813: x.
[52] Ibid.
[53] L. Smith 1999a.
[54] For example: Scull 1979, 1993; L. Smith 1999a.

with the institutions but they were not the only people with the power to shape public asylums. The running of each institution was affected by the attitudes of the lay governors, local magistrates, inhabitants of the area surrounding the asylum and friends and families of the inmates.[55]

Historian Michael Brown suggested that the early-nineteenth century asylum reform was shaped by the conflict between different conceptions of social power and public accountability.[56] This perspective helps to understand the dynamics between the laity and the medics. If at the end of the eighteenth century the physicians in charge of charitable asylums were largely left to their own devices and trusted to provide appropriate care to their patients because they were gentlemen, from the beginning of the nineteenth century they were put under severe public scrutiny and their motives and genteel benevolence were challenged.[57] Running of asylums became a matter of public concern and the reformers as representatives of the public demanded proof of medical officers' competence and fulfilment of their duties to the patients.

This was happening in the context of a larger utilitarian-inspired reform programme to professionalise the whole system of the country's government and bureaucracy. Putting specially qualified people in charge was supposed to secure the progress and prosperity of Great Britain and its peoples.[58] Public asylums were a part of the public bureaucracy and, thus, called for professional superintendents who were competent in the management and cure of the insane. Hence, to make their voices heard in discussions about insanity and increase their influence over the asylum, medical practitioners had to demonstrate special knowledge which made them uniquely qualified to tackle these topics. Establishing visible medical education on mental disease was an important tool in proving competency. It both helped to advance the interests of the medical profession and allowed medical men to learn more about this new area of practice.

Soon the lack of training on insanity became a convenient explanation of the low rates of cures in the public asylums. Relatively few patients were released from the new institutions and most came to inhabit the 'incurable' wards. The explanation for the apparent ineffectiveness of the asylum treatment was late diagnosis: allegedly, the patients reached the asylums too late, when their illness progressed beyond the possibility of successful treatment.

---

[55] L. Smith 1999a, 1999b; Suzuki 1995; Ellis 2008, 2006; Forsythe et al. 1999; Brown 2006, 2011; Murphy 2003; Bartlett 1999.
[56] Brown 2006, 2011: 82–112.
[57] Ibid.
[58] L. Smith 1999a: 22–23; Scull 1993: 124; Burney 2003, 2007; Harling 2003; Brown 2009; Desmond 1989: 10–15.

The asylum doctors claimed that nine out of ten lunatics could be cured in the asylum if they were committed early enough, so the problem was with the ability of non-specialist medical practitioners to recognise insanity in early stages.[59] Since the problem was created by the lack of knowledge the most appropriate way to address it was through education.

Hence, education on mental diseases was an important part of establishing the asylum system from the very beginning. The new institutions created the demand for new knowledge and the ways to disseminate it quickly, effectively and visibly.

2. Entrepreneurship in Early-Nineteenth-Century Medical Education

Even after the demand for new knowledge became obvious, satisfying it was not a straightforward task. In the last decades of the eighteenth century and first decades of the nineteenth, medical education in Britain was undergoing major transformations. The process of change was slow, convoluted and disjointed. In this section I will briefly outline the state of British medical training and licensing and reasons why entrepreneurial initiative played an important role in providing medical education.

As historian Susan C. Lawrence put it "[i]n bold terms, nearly anyone could practice physic, surgery, or midwifery at any time and anywhere in England and Wales in the eighteenth century."[60] Most of the country did not fall under the authority of medical licensing bodies but even in places where they existed, the licensing bodies' ability to curtail unlicensed practice was negligible.[61] As a result, regular medical practitioners had to compete for clients with each other and multitudes of irregular practitioners.[62]

Nonetheless, even if we leave the irregulars aside for a moment, licensed medical men were also not a homogenous group. First of all, there was the traditional tripartite structure of the profession which divided medical practitioners into physicians, surgeons and apothecaries.[63] Secondly, there was no single standard qualification for any of these divisions. Instead, there were sixteen separate licensing bodies whose demands on the candidates and rigorousness of testing their knowledge varied dramatically.[64] Practitioners could obtain a license from one of these bodies:

---

[59] Scull 1993: 163–64; *Morison's Proposal;* Conolly 1830.
[60] Lawrence 1996: 76.
[61] Brown 2011; Lawrence 1996; Loudon 1986; Waddington 1984: 1–52.
[62] Loudon 1986: 132–33; Peterson 1978: 5–39; Digby 1994: 9–104; Brown 2011; Oppenheim 1991: 19–20.
[63] Digby 1994: 11–38; Waddington 1984: 1-8; Peterson 1978: 6–12.
[64] Bonner 1995: 33–60; Loudon1986: 29–53; Brown 2011; Butler 1981: 1–61; Holloway 1964, 1966; Singer and Holloway 1960.

1. University of Oxford
2. University of Cambridge
3. Royal College of Physicians of London
4. Company of Surgeons (from 1800 the Royal College of Surgeons)
5. Worshipful Society of Apothecaries
6. University of Edinburgh
7. University of Glasgow
8. University of St Andrews
9. University and King's College of Aberdeen
10. Marischal College (Aberdeen)
11. Royal College of Physicians of Edinburgh
12. Faculty of Physicians and Surgeons of Glasgow
13. University of Dublin
14. College of Physicians of Ireland
15. Royal College of Surgeons of Ireland
16. Apothecaries Hall of Ireland[65]

There was also an option to receive a medical degree on the continent, for example in Paris or Vienna.[66]

The licensing bodies imposed different requirements on the applicants. The universities of Edinburgh, Glasgow and Dublin granted their degrees only after an extensive course of instruction in medical and surgical subjects and successful defence of a dissertation.[67] However, Oxford and Cambridge required little specific medical instruction from their graduates and did not offer a comprehensive course of study.[68] For example, attending lectures on anatomy only became compulsory in Oxford in 1767 and even then the students had to provide evidence of attending only one dissection.[69] The two universities in Aberdeen required even less: a medical degree could be bought from them on the evidence of recommendation letters.[70] The medical corporations did not offer any instruction and generally did not involve

[65] Loudon 1986: 132.
[66] Bonner 1995: 33–60; Loudon 1986: 132-133; Holloway 1964: 12.
[67] Rosner 1991; Loudon 1986: 132; Butler 1981: 5–11.
[68] Butler 1981: 1–29; Desmond 1989: 34–37; Singer and Holloway 1960; Bonner 1995: 33–60.
[69] Bonner 1995: 39.
[70] Loudon 1986: 132.

themselves in teaching.[71] Instead they saw their responsibility in conducting examinations for licenses and trusted that the demand for ways to prepare for these examinations would create the opportunities for learning.[72]

The medical corporations' lack of concern about professional education was especially significant, considering that their examinations served as the most popular portal of entry into the profession. Only a smaller proportion of aspiring medical practitioners in Britain trained at an academic institution and even of those who took university courses only a small percentage followed a full degree programme and graduated.[73] It was more common for medical students to audit only a few courses at universities in addition to attending private lectures and demonstrations, walking the hospital wards and apprenticing to an experienced medical practitioner.[74] As there were no clear standards for conducting such courses, no compulsory examination of knowledge or skill and no clear curriculum, the only time when the new practitioners' qualifications were tested was at the licensing examination at one of the corporations. However, even contemporary medical men doubted that those examinations were extensive and rigorous enough to ensure the quality of medical education of new practitioners.[75]

By the end of the eighteenth century the disadvantages of such a chaotic training system became obvious. When choosing the route to qualification, students frequently selected the least demanding and the cheapest option and not the one that best helped them to prepare for treating patients. Moreover, even those who wanted to obtain the best possible education struggled to identify what it was: the labyrinth of university courses, private lectures, training at hospitals and dispensaries and clinical demonstrations was difficult to navigate for the uninitiated.[76] Even more importantly, with no official standard for medical training it was virtually impossible for lay people to distinguish between regular and irregular practitioners, let alone to judge the quality of training of a licensed medic.[77] These considerations led many medical practitioners to view improvements to education and licensing as a way to enhance their social and professional status and increase their financial security.[78]

---

[71] Lawrence 1996: 74–105; Loudon 1996: 132; Waddington 1984: 1–52; Singer and Holloway 1960; Holloway 1964.
[72] Loudon 1986: 132; Lawrence 1996: 74–105.
[73] Bonner 1995: 41; Butler 1981: 1–29; Oppenheim 1991: 16–21; Singer and Holloway 1960; Holloway 1964.
[74] Bonner 1995: 61–101; Lawrence 1988, 1996; Loudon 1986: 29–53; Butler 1981: 1–29; Singer and Holloway 1960.
[75] Loudon 1986: 53–54; Butler 1981: 1–29; Peterson 1978: 5–39; Holloway 1966; Waddington 1984: 29–76.
[76] Rosner 1991: 44–62; Bonner 1995: 61–101; Lawrence 1988, 1996: 162–213.
[77] Peterson 1978: 29–30; Loudon 1986: 132–33; Brown 2011; Digby 1994: 9–104.
[78] Loudon 1986: 133; Digby 1994: 9–104; Holloway 1964, 1966.

At the turn of the nineteenth century the dissatisfied medical men actively pushed for reform. They were motivated by both extra- and intra-professional factors. Among the former the most important ones were that, first, the period of peril associated with the French Revolution and the Napoleonic Wars created a high demand for well-trained and versatile medical officers for the army.[79] Secondly, the Industrial Revolution, increasing urbanisation and growth of Britain's population led to an increased demand for medical services.[80] Thirdly, whereas wealthier patients tended to choose physicians and "pure" surgeons as their attendants, less well-to-do clientele preferred the cheaper services of the emerging breed of medical practitioners — surgeon-apothecaries or, as they became known later, general practitioners.[81] Finally, the changing conceptions of social power and public accountability, which we discussed in the previous section with regards to the asylum reform, influenced the medical profession as a whole and not only the part of it connected to treating the insane.[82] It was not enough to demonstrate gentlemanly conduct and benevolence to instil trust in the public and support the practitioners' authority; evidence of professional training and expertise was also required.

The main intra-professional explanation for the medical reform, according to historian Irvine Loudon, was "that medicine as a whole had grown up so rapidly in the eighteenth century that it was outgrowing its institutions".[83] First, the emergence of general practitioners challenged the traditional tripartite structure of medical profession and threatened the interests of the medical elites whose power was connected to their high positions within the medical corporations.[84] The general practitioners were quickly developing into a clear professional group distinct from other medical divisions. They did not feel that their interests were represented by any of the corporate licensing bodies, nor did they have any ties with academic institutions since general practice did not require a university degree. The condescending treatment they received from the Royal Colleges who saw them as inferior to those practicing "pure" surgery or physic did not improve the relationships between the general practitioners and the medical elites.[85] Furthermore, the medical corporations of London, although highly influential, represented the interests of only metropolitan practitioners, not having any legal

[79] Mackintosh 2021; Lawrence 1996: 100–04.
[80] Holloway 1966: 112–13; Waddington 1984: 53–76; Oppenheim 1991: 18–20.
[81] Holloway 1966; Peterson 1978: 16–30; Oppenheim 1991: 19–20; Waddington 1984: 9–28.
[82] Brown 2011: 82–149; Bonner 1995: 142–57; Graham 2021.
[83] Loudon 1986: 131.
[84] Digby 1994: 11–38, 107–34; Loudon 1986: 189–207; Waddington 1984: 9–52; Peterson 1978: 16–30; Holloway 1966.
[85] Loudon 1986: 129–50; Peterson 1978: 16–30; Butler 1981: 14–24; Waddington 1984: 29–52.

authority over or interest in provincial practice. Hence, while the rank-and-file medical men struggled to make a decent living competing with various irregular practitioners and to gain the respect of the public, the licensing bodies largely disregarded their strife and focused instead on maintaining their privileged positions.[86]

Therefore, general practitioners and provincial medical men were the main drivers of the medical reform. The Association of Apothecaries and Surgeon-Apothecaries was the most active body campaigning for change, and it put the issues of education and licensing at the heart of its agenda. The Association put forwards two main demands: first, to make "medical educations based on broad curriculum and tested by examination" a necessary requirement for medical practice, and second, to establish "a process of licensing by which the irregular practitioners could be clearly distinguished by the public from the genuine educated medical men".[87]

As with the asylum reform movement, the proponents of medical reform argued that the change would not just benefit the profession but would serve the public good and address the needs of the nation.[88] They argued that:

> Apothecaries and surgeon-apothecaries are the most numerous class of medical practitioners: their duties are of very serious and individual interest, the lives and health of by far the greater part of the community being entirely confided to their care, without in many instances the possibility of obtaining other advice; yet there [sic] are allowed to practice without any examination or test of competency whatever; so that, any person, however destitute of medical or even common education, may assume with impunity the character and functions of the apothecary. This is a great source of evil both to society and themselves.[89]

In the early nineteenth century framing issues of medical education and reform in terms of public wellbeing and protection of patients from incompetent or malevolent practitioners was a new development.[90] This rhetoric was aimed at combating the widespread assumption that robust competition of the medical market would ensure that only the best qualified practitioners prospered and there was no need for legislative intervention, especially on a national level. It did not convince everyone but nonetheless it offered a justification for curtailing unlicensed practice, apart from medical men's desire to eliminate competition.

---

[86] Peterson 1978: 6–12; Butler 1981: 19–24, Loudon 1986: 172; Waddington 1984: 29–52.
[87] Loudon 1986: 160.
[88] Graham 2021; Brown 2011: 113–49; Loudon 1986: 154–55; Waddington 1984: 53–76.
[89] *Medical and Physical Journal*, 29 (1813): 346–47.
[90] Brown 2011: 129–37; Loudon 1986: 154.

Even with the relentless efforts of some passionate campaigners since 1793, it was not until 1815 that a legislation to regulate general practice was enacted. It was partly because of the resistance of the medical corporations of London and partly because with the Napoleonic Wars there were many more pressing political issues which overshadowed medical reform.[91]

The Apothecaries Act of 1815 came into power on 1 August. It was a result of years of fierce deliberation between various concerned parties, and none of them were happy with the outcome. Therefore, the campaign for reforming medicine did not stop there and the demand for further changes continued.[92] However, the Act had some important consequences and set several ground rules for the education of general practitioners.

First of all, it put the licensing of general practitioners under the purview of the Society of Apothecaries. The new qualification was called the License of the Society of Apothecaries (LSA). To obtain it the candidate would have to be at least twenty years old, have served for 5 or more years as an apprentice to an apothecary and provide testimonials of "sufficient medical education and good moral character".[93] Then they would have to pass an examination by the Court of Examiners chosen by the Master and Wardens of the Society of Apothecaries.[94] The Act did not define what constituted "sufficient medical education," leaving it to the Society, which established the following requirements:

1. Before presenting themselves for the examination the candidate must have completed:
    - two courses of lectures on anatomy and physiology;
    - two courses of lectures on the theory and practice of medicine;
    - one course of lectures on chemistry;
    - one course of lectures on the *materia medica*
    - six months' attendance at a hospital or a dispensary.
2. At the examination they were tested on their knowledge of:
    - theory and practice of medicine;
    - pharmaceutical chemistry;
    - *materia medica.*[95]

[91] Mackintosh 2021; Holloway 1966; Loudon 1986: 129–70.
[92] Holloway 1966; Cowen 1969; Loudon 1986: 166; Waddington 1984: 53–76; Graham 2021; Butler 1981: 14–18; Lawrence 1996: 91–106.
[93] Holloway 1966: 125.
[94] Ibid: 124.
[95] Cope 1956: 4.

Although a general practitioner was supposed to be sufficiently competent in both medicine and surgery, the LSA did not require surgical training. Hence it became common to pass the member's examination at the Royal College Surgeons (MRCS) to substantiate one's surgical skills.[96] Conspicuously, none of the medical corporations offered training courses beyond a few sporadic lectures for the members and their apprentices. The students were expected to find opportunities to learn all the required subjects themselves.

This was not a new turn of events. The corporations' indifference to medical education and the laissez-faire approach to regulating it allowed for a thriving scene of extra-academic training which blossomed in the second half of the eighteenth century.[97] It was especially vibrant in London, followed by Edinburgh and Glasgow, but there was a significant number of educational initiatives in the English provinces too.[98] In fact, to a large extent medical corporations did not interfere with educational activities in order to make sure they were not infringing on their members' rights to teach and earn a living from lecturing or on the universities' traditional practice of educating physicians.[99]

Much of the instruction available to British medical students in the period between 1792 and 1840 was offered by entrepreneurial medical practitioners outside the walls of academic institutions. London was the most striking example of it, as it was one of the largest centres for medical learning in Europe and yet, until 1828 it did not have a university.[100] In London, teaching was available in the form of courses by independent lecturers, clinical training at numerous hospitals and demonstrations at private schools of anatomy.[101] In Edinburgh and Glasgow, where universities offered a comprehensive programme of medical study, existed a lively scene of extra-mural education.[102] For example, the medical school of the private "Anderson's University" in Glasgow, opened in 1800, in a few years started attracting more students than the University of Glasgow.[103]

By the 1800s academic teaching in Britain, as in the rest of Europe, came under severe criticism. The students were dissatisfied with how theoretical and impractical university training was. They found the professors too detached, continued use of Latin annoying, and the

[96] Loudon 1986: 175–76; Lawrence 1996: 104–107; Waddington 1984: 14–15.
[97] Lawrence 1988, 1996: 75; Desmond 1989: 152–92.
[98] Bonner 1995: 52; Brown 2011: 13–81; Rosner 1991.
[99] Lawrence 1996: 76; Waddington 1984: 29–51.
[100] Bonner 1995: 47, 116; Lawrence 1988, 1996: 162–214; Desmond 1989: 101–92; Singer and Holloway 1960; Holloway 1964; Butler 1981: 1–61.
[101] Bonner 1995: 47; Lawrence 1988, 1996: 167–75; Desmond 1989: 101–92.
[102] Rosner 1991; Jacyna 1995; Butler 1981: 5–11; Bonner 1995: 43–56.
[103] Bonner 1995: 52.

emphasis on academic knowledge insufficient to prepare them for practice.[104] On the other hand, there was a deficit of opportunities for acquiring practical knowledge. Until the Anatomy Act of 1832, the constant shortage of bodies for dissections significantly limited the occasions for practical study of anatomy.[105] Clinical lectures, although immensely popular, were so crowded that it was almost impossible to observe the cases and hear professors' commentary. There also was precious little practical instruction in surgery or physic.[106]

Therefore, extra-academic teaching flourished because it answered the needs of medical students not fulfilled by the universities. In England medical education offered by Oxford and Cambridge was expensive, poor and incomplete.[107] Moreover, there was no option of auditing classes without matriculation and both universities were far from large hospitals where students could acquire practical skills.[108] However, the burgeoning teaching industry of London offered all the education needed for entering into the profession.[109] In Scotland the most successful extra-mural courses were those which either provided training lacking at university medical schools or offered better instruction.[110]

Most teachers of medical subjects saw teaching as a source of income and improvement of their social status and professional standing by popularising their own theories and techniques. Famous lecturers did not only attract paying pupils but also caught the attention of wealthy patrons and patients.[111] Private teaching was not a new form of entrepreneurship. By the mid-eighteenth century, London was already bustling with lectures and courses on various subjects "from navigation, applied mathematics, popular science, and law to dancing, foreign languages, and classical literature."[112] These courses offered a way to obtain gentlemanly knowledge and skills for those who could not attend a university but wanted to advance themselves in polite society. So medical entrepreneurs joined the throngs of existing private teachers.

Private teaching was not overseen by any academic or professional body and the entrepreneurial teachers had no obligation to follow a specific programme and nor to guarantee

[104] Bonner 1995: 81–89; Rosner 1991: 11–25.
[105] Lawrence 1988, 1996: 188–211; Rosner: 44–62; Butler 1981: 11–14; Holloway 1964; Richardson 1988; Brown 2011: 113–49.
[106] Bonner 1995: 83; Rosner 1991: 44–62; Butler 1981: 1–29.
[107] Waddington 1984: 3–4; Singer and Holloway 1960; Desmond 1989: 34–37.
[108] Bonner 1995: 34–43; Lawrence 1988; Peterson 1978: 12–16.
[109] Lawrence 1988, 1996; Singer and Holloway 1960; Butler 1981: 11–14; Singer and Holloway 1960; Holloway 1964; Desmond 1989: 152–65.
[110] Bonner 1995: 90–91; Rosner 1991.
[111] Rosner 1991: 11–51; Lawrence 1988, 1996: 162–211; Peterson 1978: 5–39; Waddington 1984: 29–52.
[112] Lawrence 1988: 174.

that their pupils would reach a specific level of mastery by the end of the course. They were only obligated to deliver lectures at specific times and places and admit all those who paid the fee to attend. In this respect the extra-mural teaching provided much freedom. However, as with all forms of entrepreneurship, medical teachers had to bear all the risks.[113] They had to recruit enough students to make a living. Hence, in the highly competitive environment of medical teaching, they had to offer competent instruction on subjects which were in demand amongst students and, ideally, possess some signs of professional distinction. Moreover, they had to offer all that at a competitive price.

Another important aspect of a successful teaching career was a good supply of bodies for dissection (especially for anatomy schools) and patients for clinical demonstrations and practice.[114] This was one of the main attractions of the Great Windmill Street school of anatomy. As the memoir of a famous English surgeon Sir Benjamin Brodie (1783–1862) demonstrates, even with an unenthusiastic instructor like the Welshman Honoratus Leigh Thomas (1769–1846) or a yet undistinguished demonstrator, as Brodie was at that time, access to corpses for dissection was enough to keep the school extremely popular.[115]

Clinical teaching connected to a hospital or dispensary was popular for similar reasons. The students there could encounter multitudes of cases and practice clinical skills. They could also observe and even assist in surgical operations. Even those students who completed their years of apprenticeship would not have been exposed to such a great variety of cases and state-of-the-art techniques as the hospital pupils.[116] The surviving attendance registers demonstrate the growing popularity of hospital teaching: in 1780 there were 91 students recorded, but their number increased to 250 by 1814 and 310 by 1820.[117] However, even with the growing popularity of hospital teaching and extra-mural schools, independent lecturing was still common.[118]

There was also another form of independent medical teaching, often overlooked by literature on medical education — lecture courses and demonstrations on heterodox medical theories, for example homeopathy, mesmerism and phrenology.[119] The latter two are especially relevant to this thesis since both offered explanations and possible treatments of mental

[113] Lawrence 1988, 1996: 162–211; Desmond 1989: 152–93.
[114] Bonner 1995: 81–89; Lawrence 1996; Desmond 1989: 152–193; Singer and Holloway 1960; Richardson 1988; Browne 2011: 129–37.
[115] Hawkins 1865: 37–40.
[116] Bonner 1995: 103–41; Lawrence 1988, 1996; Singer and Holloway 1960; Peterson 1978: 12–16; Butler 1981: 1–29; Holloway 1960.
[117] Lawrence 1988: 178.
[118] Ibid: 180.
[119] For an overview of unorthodox medical practices see Bynum and Porter 1987; Cooter 1988; Saks 1992.

disease.[120] Although both were never fully embraced by the medical profession, they nonetheless had numerous proponents amongst the regular medical practitioners and were included in the lecture courses by some teachers.[121]

Between 1792 and 1840 medical learning was almost as entrepreneurial as medical teaching. With multiple portals of entry into the medical profession and absence of a curriculum or standard requirements for medical license, the students had to chart their own educational course. They had to choose wisely as in the extremely competitive market of medical services just having a qualification was not enough to succeed and there was a strong incentive to look for courses which would provide further advantages in the students' intended careers.[122]

Most men embarked on medical education in their late teens and were confronted with an overwhelming number of options. They did not have to limit themselves to just one institution or even one geographical location.[123] It was common to attend additional extra-mural classes even amongst the students who wished to obtain a degree from a Scottish university and followed a comprehensive academic course.[124] Many students chose a peripatetic model dividing their studies between Scottish universities, London medical schools and hospitals, and the schools and universities of Continental Europe. Historian Thomas Neville Bonner summarised this DIY approach to medical education in the following way:

> To a very large degree, the students were the organisers of their own education, putting together a combination of experiences through serving a master, walking the wards of a hospital, perhaps taking a course in a private home or hospital, serving in the army or navy, attending a school of surgery or military medicine, and sometimes following lectures at a university.[125]

Furthermore, medical students did not only have to choose which subjects to study and under whose tutelage, but also in what order to take them. Depending on their financial and social situation aspiring practitioners could determine the length of their studies. Some selected to take as many courses as possible in the shortest amount of time and some preferred to spread their training over a longer period.[126] In addition to this, for many young practitioners,

---

[120] For a detailed history of mesmerism and its uses in Britain see Winter 1998. For the history of phrenology see Cooter 1984; Van Wyhe 2004.
[121] For example, John Elliotson (1791–1868), a professor at the University College London, was a staunch supporter of both mesmerism and phrenology (Winter 1998: 32–59, 79–109); W. A. F. Browne (1805–1885), a celebrated alienist, was one of the most vocal promoters of phrenology (Scull et al. 1996: 84–122).
[122] Lawrence 1988; Bonner 1995: 61–102; Rosner 1991: 11–130; Holloway 1964.
[123] Butler 1981: 1–55; Lawrence 1988, 1996: 74–211; Bonner 1995: 33–140; Singer and Holloway 1960.
[124] Rosner 1991: 44–61.
[125] Bonner 1995: 44.
[126] Bonner 1995: 61–101; Rosner 1991: 25–44; Holloway 196feather; Singer and Holloway 1960.

especially those who coveted a university position, learning did not stop after obtaining a degree or non-academic qualification.[127] They continued to attend extra-academical courses and clinical lectures, and often travelled to the continent to train further under celebrated European teachers. After the end of the Napoleonic wars Paris became one of the most popular medical travel destinations. Not only did it offer courses by famous teachers and opportunities for clinical experience, but, before the passing of the Anatomy Act in Britain, medical students in Paris paid on average thirty times less for bodies for dissection than their peers in Britain.[128]

Some practitioners later considered the opportunity to plot their own course as a great advantage. For example, Benjamin Brodie in his autobiography reminisced about the good old days of his studentship at the turn of the nineteenth century when

> [n]o rules were laid down as to the number of lectures which I was required to attend. The examination at the College of Surgeons was sufficiently good, as far as it went, but it was of a very simple and elementary kind. It was no more than a diligent student might pass without any special preparation for the purpose. The consequence was that I was enabled to take my education very much upon myself; […] I was acquiring knowledge in [many] ways.[129]

The situation did not change much by the 1830s when another famous English surgeon Sir James Paget (1814–1899) was going through his medical training in London. Of that period, he wrote:

> For the great majority of students, and for myself at first, work at that time had to be self-determined and nearly all self-guided: it was very little helped by either the teachers or the means of study.[130]

Later in his *Memoirs* Paget aptly summarised his teachers' approach to education: "it was customary to think it sufficient to *give opportunities* for learning."[131] It was the students' responsibility to seize those opportunities.

It would be impossible for the young men to navigate this maze of an educational system on their own. Fortunately, they had help. First of all, many of the prospective students arrived to one of the centres of medical teaching with strict instructions from their medically

---

[127] Rosner 1991: 59.
[128] Bonner 1995: 87; Holloway 1964: 16–17.
[129] Hawkins 1865: 38–39.
[130] Paget and Paget 1902: 40.
[131] Ibid: 60. Emphasis mine.

trained relatives on how to best conduct their studies.[132] Secondly, young men who did not hail from medical families often had a letter of introduction to one of the successful practitioners at the place of study. These practitioners served as mentors and advised their charges on educational, career and social choices.[133] Another source of advice was their fellow students. Historians Lisa Rosner and Susan C. Lawrence in their work on medical education in Edinburgh and London respectively noted that students shared their opinions and useful tips with their peers.[134] Finally, there were printed guides to inform the students' educational choices. They were published in medical periodicals or, like J. Johnson's *Guide for Gentlemen Studying Medicine at the University of Edinburgh*, were available as separate publications.[135]

In the period between 1792 and 1840 British medical education as a whole was mostly unregulated, disorganised and depended on the entrepreneurial spirit of individual teachers and students. Although, this time was characterised by active attempts to reform medical profession which centred on improving and regularising medical education and licensing, these efforts had not yet led to the establishment of standard medical curriculum or unified requirements for obtaining a qualification. In this context, even with the growing demand for new knowledge about mental disease in the medical community, it could not just become a part of medical curriculum, since there was no such thing, but, like most other medical teaching, the demand for medico-psychological knowledge was met by the appearance of private lecture courses.

3. Entrepreneurial Teaching on Mental Diseases: Alexander Morison

The first medical practitioner who anticipated the demand for medical knowledge on insanity and attempted to capitalise on it was a Scottish physician Alexander Morison (1779–1866). He organised a comprehensive course of lectures on mental diseases in 1823 and ran it annually until 1844 in Edinburgh and in London. The way Morison went about arranging his lectures was in keeping with the mainstream of medical education: the course was unaffiliated with a university, entrepreneurial, not restricted by an external educational standard and aimed at providing students with a competitive advantage on the medical market. Hence, it presents us with a great opportunity to zoom in on this well-documented example and examine the fine details of teaching on mental disease in the early nineteenth century. In this section I will provide an account of how Morison established his course, describe its contents, outline further

[132] Bonner 1995: 70–72; Rosner 1991: 44–62; Lawrence 1988.
[133] Rosner 1991: 44–62, Bonner 1995: 70–72.
[134] Rosner 1991: 44–62; Lawrence 1988; 1996: 162–215.
[135] Johnson 1792.

developments in Morison's teaching and analyse his audiences.

Peculiarly, Morison was not an asylum doctor, nor did his practice noticeably lean towards the care for the insane at the time when he proposed his lecture course. Morison's training followed the usual pattern of the period: he studied at the University of Edinburgh and apprenticed to a surgeon for five years. Then, having graduated with an MD degree in 1799, he went to London to gain more clinical experience at the teaching hospitals there. In the same year he married 16-year-old Mary Anne Cushnie, who in addition to her beauty possessed a third of a successful sugar plantation in Jamaica. Hence, until 1815, when the returns on his wife's estate diminished drastically, Morison had not depended on his medical practice for his income. He spent the fifteen years travelling, making an unsuccessful attempt to settle in London, serving as house physician to several influential Scottish aristocrats and gaining useful acquaintances.[136]

So why then, when his financial situation worsened did Morison decide to set his hopes on establishing himself as a doctor to the insane? First of all, he was influenced by the longstanding and formative friendship with Alexander Crichton (1763–1856), a leading British expert on mental disease.[137] Morison met Crichton in Edinburgh in the early 1790s and renewed their acquaintance in London.[138] Crichton became Morison's mentor and encouraged his interest in insanity. Secondly, the downturn in Morison's financial circumstances coincided with the 1815 Select Committee on Madhouses. The publicity which surrounded the activities of the Committee attracted Morison's attention. Furthermore, with the asylum reform movement gaining momentum it seemed likely that there would follow an expansion of professional possibilities in the treatment of insanity. Morison sought to seize the new possibilities as soon as they arrived. Through his network of influential acquaintances, he started canvassing for potential posts, for example as a member of the Lunacy Commission proposed by in one of the Madhouses Bills in 1817.[139]

Unfortunately, as discussed in Section 1, the legislative efforts of asylum reformers after 1808 did not pay off until much later in the century. Nevertheless, Morison continued his quest to establish himself as an expert on mental diseases. To this end he arranged a trip to Paris in 1818 to visit its famous hospital and asylums. There he studied under Jean-Étienne Dominique Esquirol (1772–1840) — a student of Philippe Pinel (1745–1826) and a celebrated

[136] Scull et al. 1996: 126–31.
[137] *DNB*; Weiner 1991.
[138] Scull et al. 1996: 126–27.
[139] Ibid: 131–35.

alienist in his own right.[140] Morison was profoundly influenced by his approach to insanity. He visited Esquirol four more times and, until Esquirol's death in 1840, the doctors maintained a lively correspondence and sent students to each other with letters of introduction.[141] Back in Britain Morison cultivated relationships with asylum and insanity specialists amongst his compatriots. He visited the York Retreat and the new Wakefield Asylum which functioned on the same principles of treatment. During the visit, he befriended the superintendent William Ellis and consulted the asylum's architect. Morison also got an introduction to St. Luke's physician Alexander Robert Sutherland and through him connected with the Glasgow asylum's medical officer Mr Doury.[142]

Morison's activities clearly show that he was putting significant effort into acquiring specialist knowledge on insanity and useful connections to advance his career in that direction. However, his income still came from general practice. Consequently, in 1819, when Morison's hopes of gaining a position as a Lunacy Commissioner or a paid visitor to private asylums fizzled out, he looked for employment as a generalist and secured an appointment as travelling physician to the adult daughters of a prominent London banker Thomas Coutts (1735–1822): Lady Bute and Lady Gillford.[143] For a couple of years he accompanied the ladies, their children and entourage across Europe in search of better climates and improved health. This was a common reason to travel at the time and taking one's own physician on the voyage was common too, lest the wealthy traveller had to consult a foreigner.[144] Although unknown to Morison at the time, this appointment was crucial for kick-starting his teaching career and consultancy on insanity.

Morison returned to England in 1822 and was hired as an in-house physician by Harriot Coutts (1777–1837), the recently widowed stepmother of the ladies he accompanied in Europe.[145] Mrs Coutts was an extraordinary character for her time. Before marrying a respectable banker, she was a popular actress at the Drury Lane Theatre. Her wedding to Thomas Coutts after a decade-long affair and a very short time after the death of his first wife was a scandal. Even more preposterous was the fact that Mrs Coutts inherited her late husband's entire fortune.[146] Morison's appointment to Mrs Coutts's household only lasted a year but it was a pivotal year, since it yielded the idea of Morison's lecture course and the

[140] The works and influence of both French physicians will be discussed further in Section 4 of this chapter.
[141] Ibid: 132–33. For more information see D. Weiner 1991, 2000; K. M. Jones 2019: 44–88.
[142] Scull et al. 1996: 134; Hunter and Macalpine 1968: 11–15.
[143] Scull et al. 1996: 134–35.
[144] Digby 1994: 199–221.
[145] Scull et al. 1996: 135.
[146] Perkin 2002.

necessary funds to establish it.

As explained earlier in this chapter, medical teaching could be a lucrative enterprise and could aid the teacher's private practice. Morison was in dire need of funds. He was also interested in insanity and anticipated the growing demand for professional knowledge in this area. Moreover, he clearly had ambitions to obtain a high position within the growing insanity market. Becoming a lecturer on mental diseases would help Morison advance towards all those goals, but private lecturing required a significant investment of funds which he did not possess. Luckily, his employer, Mrs Coutts, was sympathetic to the plight of the poor and insane, and was also looking for a way to commemorate the memory of her late husband in a meaningful way.[147] Both Thomas Coutts's older brother and first wife suffered from prolonged mental illness.[148] So, when Morison approached Mrs Coutts with an idea of establishing a lectureship in mental disease at the University of Edinburgh in memory of Thomas Coutts, she approved the idea and pledged an endowment of £100 per annum to pay the lecturer's salary.[149]

In addition to the Coutts's endowment Morison started a lecture fund and approached his rich and influential acquaintances for donations and subscriptions.[150] In just a few months he managed to secure over £1200 and invested most of it into residential property in Edinburgh.[151] This money was supposed to pay for all the expenses associated with the lectures — lecture room rent, costs of advertising in newspapers, teaching materials and so on.[152] If anything from these or student fees was left after paying for the expenses the lecturer could add it to his salary.

While gathering the funds for his enterprise Morison was also trying to figure out how to affiliate his course with the University of Edinburgh by creating a professorship in mental diseases. He decided to follow the example of the procedure followed when the professorship in agriculture was established in Edinburgh in 1790.[153] Hence, he accumulated a sufficient sum through subscription, formalised the endowment from Mrs Coutts and collected letters of support from prominent members of society and medical practitioners. The list of Morison's advocates included the Duke of York, Prince Leopold, Sir Henry Halford (President of the RCP of London), Dr Matthew Baillie, Sir James McGrigor (Director General of the Army Medical

---

[147] Ibid.
[148] *DNB.*
[149] "Diaries of Sir Alexander Morison", RCPE, DEP/MOR/1*,* 8 January 1823. Hereafter: *Morison's Diaries.*
[150] Morison's diary provides a detailed record of its owner's activities and demonstrates that he spoke or wrote to someone about the lecture fund almost every day in 1823 and 1824.
[151] *Morison's Diaries,* 28–29 March 1823; 10 April 1823.
[152] Ibid, 12 January 1824.
[153] Ibid, 26 January 1823.

Department) and Drs Alexander Robert Sutherland and John Haslam (both prominent physicians specialising on treating the insane).[154] Having assembled all of the above, Morison finally approached the University of Edinburgh with a proposal

> that a Lectureship be established for the consideration of Diseases of the Mind, a measure calculated to prevent abuses in the management of the Insane, to lessen their number, and to extend the knowledge of improvements in the treatment of a numerous class of disorders, more prevalent in this Country than in any other.[155]

The way Morison expressed the goals of the course demonstrated that he was keeping a close eye on the discussions surrounding the asylum reform. He struck at the most painful places: the damage to the reputation of the medical profession caused by the abuses in madhouses and subscription asylums, the rising numbers of the insane and the seeming backwardness of Britain in dealing with this problem compared to other countries.

Nevertheless, the laborious preparation work and carefully crafted justification did not convince the faculty of the Edinburgh Medical School. Through his network of friends Morison discovered the reasons for his proposal's refusal. According to his sources, the faculty members were concerned that mental diseases were "not a broad enough ground for a separate professorship"; the lectureship on diseases of the mind could encroach on the other professors' subjects; and that the salary of £100 per annum, proposed by Morison "was so small & the number of the students could not be many […] that future Lecturers would not be able to live by it".[156]

It appears that Morison's main opponent at the university, professor of chemistry Thomas Charles Hope (1766–1844), had significant influence over both the medical faculty and the university senate. Hope argued that "any old dropsical gentleman might choose to leave a fund for a separate lectureship on Dropsy or liver disease if some line was not drawn & the attention of students distracted".[157] Or, if translated into plain English, that even very wealthy laymen should not influence the university curriculum and that establishing lectureships on new specialised subjects would detract students from other courses and the existing professors would suffer financial losses. Morison did not give up and approached Hope directly: first by letter elaborating on the arguments for the establishment of the course and enclosing the

[154] *Morison's Proposal; Morison's Diaries,* 21–22 January 1823.
[155] *Morison's Proposal.*
[156] *Morison's Diaries,* 23–24 March 1823.
[157] Ibid., 24 March 1823.

recommendations from Drs Crichton and Baillie; then in person. Hope remained steadfast in his opposition, although he admitted that "there was no doubt Lectures on M.D. [Mental diseases] might be useful". He then went on to say "that 15 lectures would be as much as could be given" on mental diseases and that "the grand thing would be to attach it to the Professor of Physic obliging him to give 15 Lectures" on the subject, instead of creating a separate course.[158] Morison continued his campaigning but did not meet with success. Even those who considered the idea favourably were not optimistic about the outcome. Instead, they suggested that Morison tried to affiliate himself with other institutions, in particular, the Royal College of Physicians of Edinburgh or a functioning lunatic asylum.[159]

In April 1823 Morison had to return to London and continue his medical ministrations to Mrs Coutts. However, as the conditions of the endowment specified that the first course had to be delivered by the end of 1823, Morison carried on preparing for the lectures. He spent the following six months developing the content and learning about best teaching practices. The records in his diary demonstrate that he spent considerable time reading on insanity, for example, he mentioned Benjamin Rush, Franz Josef Gall, Johann Gaspar Spurzheim, Étienne-Jean Georget (in French), John Locke, James Cowles Prichard, and John Ayrton Paris and John Samuel Martin Fonblanque.[160] Furthermore, Morison visited London asylums and attended medical lectures, including Gall's course on phrenology in London.[161] By October 1823 Morison developed a plan for his course and discussed it with several of his medical friends, including his mentor, Alexander Crichton. The latter "very much approved" of the plan and made a few suggestions for improvement.[162]

The situation with attaching the lectures to the university was still not resolved but with the year almost over Morison decided to carry out the first course in November 1823

---

[158] Ibid., 27 March 1823.
[159] Ibid., 25 and 27 March 1823.
[160] A more detailed discussion of the literature on insanity available during this period will follow in the next section of this chapter. B. Rush (1746–1813) was a Founding Father of the United States and a physician, who received an MD degree at the University of Edinburgh and had a special interest in mental diseases. F. J. Gall (1758–1828) and J. G. Spurzheim (1776–1832) were German physicians who developed phrenology. J. Locke (1632–1704) was an English philosopher who developed a theory of mind which significantly influenced the Enlightenment understanding of insanity. J. C. Prichard (1786–1848) was a British physician who had a special interest in insanity and published on it, and in 1835 he introduced the diagnostic category of "moral insanity". J. A. Paris (1785–1856) was a British physician and J. S. M. Fonblanque (1787–1865) was an English lawyer. They co-authored an influential book on medical jurisprudence which included an extensive discussion of insanity.
[161] Gall was the founder of phrenology and a highly skilled anatomist. In the 1820s phrenology was very popular in Britain among medical and lay audiences alike. Morison attended Gall's lectures for the phrenological explanations of mental illness and health and for the brain dissections. For more information on phrenology see Cooter 1984, Van Wyhe 2004. For the significance of phrenology for British alienists see Cooter 1981, Quick 2014.
[162] Ibid, 5 November 1823.

independently in a hired room in town. Although he did not discuss it openly in the diary, it seems like he treated this first teaching session as a prototype, in the true entrepreneurial spirit. He advertised it in Edinburgh newspapers but not very widely and was not concerned about the poor attendance: there never were more than seven people present at a lecture and only four came to all thirteen of them. During the course Morison continued to rally for establishing a professorship at the university. He gave free tickets to prominent Edinburgh doctors and influential inhabitants, spoke of his teaching endeavours at gathering in the Royal College of Physicians of Edinburgh and at the end of the course printed several hundred of prospectuses with general information and a list of topics covered.[163] He used them in promoting his pedagogical efforts both in Edinburgh and later in London.

Let us examine the contents of Morison's course. In 1823 he gave 13 lectures which covered the following topics:

1. a concise description of the brain, and of the mental faculties in the sane state;
2. an account of delirium febrile and insane;
3. the nosological divisions of the insane state;
4. the ordinary progress of insanity, including
    a) The incipient state
    b) The confirmed stage
    c) The decline and convalescence, and
    d) The uncured state;
5. the deviation from the ordinary progress;
6. the causes of insanity, moral and physical;
7. the treatment, medical and moral;
8. mental imbecility, general and partial;
9. delusions, with and without consciousness;
10. disorders of the passions, of attention, and of sleep.[164]

Morison noted the lecture topics and attendance in class but did not go into detail about what he taught under each heading. Unfortunately, there are also no published records of these first lectures. However, after his second course the in following year Morison issued a pamphlet

[163] The course took place from 21 November to 19 December 1823, *Morison's Diaries* for this period contain a record of his meetings, lecture attendance, letters and so on.
[164] *Morison's Diaries,* 21 November–19 December 1823.

called *Outlines of Lectures on Mental Diseases*. Judging by the lecture titles, the content of the course did not change significantly, so we can use the pamphlet to gain a more detailed insight into Morison's teaching. The *Outlines* was not a full transcript of the lectures but, just as the title suggested, a detailed outline with the structure of each topic, key terms and definitions and major theories. The reviewer in the *Lancet* aptly described it as

> more the framework of a system, than a practical treatise on the subject of insanity; [it] consists, principally, therefore, of definitions, general directions, statements and particulars, nosological distinctions, and aphoristic remarks.[165]

The format of the publication was not coincidental, since it was helpful to the students who attended the lectures but could not be used instead of the lectures. The students could use the pamphlet as a workbook during the course, adding their own notes to it, they could copy the structure of the *Outlines* and make their manuscript notes easier to navigate, or they could use it for revision.[166] The publication was not written in full sentences and did not contain original theories or complete arguments. Nevertheless, the *Outlines* still offers much to a historian. I would like to draw particular attention to three specific aspects of the pamphlet.

First of all, it demonstrates that Morison's work was primarily pedagogical. The course consisted of summarised and systematised British and European medical practitioners' understanding of mental disease. Morison did not propose original ideas, instead the course's aim was to communicate existing knowledge in an understandable and practical manner. This aspect distinguished Morison from the lecturers who delivered courses to disseminate specific theories and practices, for example, phrenology. In contrast to the narrow scope of such courses, Morison's lectures provided a survey of all the most popular, even if at times contradictory, medical approaches to insanity. For instance, he gave several definitions of the same term by different practitioners or, when speaking about the "Fabric of the Nerves" stated that there were two opposing opinions and reasoning for them, leaving it to the student to choose a side.[167]

Secondly, Morison did not just summarise texts but visited asylums and interviewed medical practitioners about their practice. For example, in January 1824 he consulted Alexander Robert Sutherland and John Haslam, both recognised authorities on insanity, on

---

[165] *Lancet*, 8 (1827): 54.
[166] For a detailed discussion of the Scottish students' notetaking practices and their uses of "outlines" or "syllabus" provided by the lecturers see Eddy 2016 (especially pp. 100–09).
[167] Morison 1825: 11.

force feeding: when it was necessary, best methods and alternative techniques.[168] Morison served as a visitor to Surrey madhouses and, thus, had a chance to observe practices there. In addition, Morison arranged visits to asylums around the country. He took extensive notes on those visits and asked many detailed questions. For example, only in January 1824 he visited a private asylum in Clapham, St. Luke's Hospital and Bethlem in London and, on his way back to Edinburgh, Liverpool Lunatic Asylum and a large asylum near Lancaster.[169] Morison paid special attention to the instruments, furniture and other contraptions used in asylums to ease management of the insane. When he encountered especially useful objects, he obtained them to show to students during the lectures or sketched them in his diary. For instance, in Liverpool he bought "wrist & ancle [sic!] manacles invented by Mr Davis [the superintendent] of leather."[170] He also demonstrated various other restraints and contraptions for force-feeding obtained from Haslam and Sutherland.[171]

Finally, the *Outlines* went through several editions and reflected changes in Morison's lecturing over time. The most noticeable ones were related to his teaching on mesmerism and phrenology. In the first two years Morison included a significant amount of information on both, but his opinions changed later. He viewed mesmerism sceptically from the outset but incorporated it in the last lecture of his course in 1823 and mentioned it in the following years.[172] In the first edition of the *Outlines* Morison cautioned that the effects of animal magnetism were "referred by many entirely to the imagination of the magnetised".[173] In 1829 he took a more definite stance on the issue by claiming that "the effects alleged by them [magnetists] to depend upon human magnetism may be much more reasonably referred to the imagination of the magnetised."[174]

Morison's relationship with phrenology was more complex. During his first visit to Paris in 1808 he attended Gall's lectures and was impressed by them. His friend and mentor Alexander Crichton was also interested in phrenology and suggested Gall's work to Morison.[175] In 1823 he met Edward Wright, the superintendent of Bethlem and an influential

---

[168] *Morison's Diaries,* 24 January 1824. A. R. Sutherland (1781–1861) had been a physician at St. Luke's Hospital since 1811 and J. Haslam (1746–1844) served as an apothecary at the Bethlem Hospital from 1795 to 1816. Even though the latter was dismissed as a result of the 1815-16 Select Committee investigation of madhouses, Haslam rebuilt his reputation and published extensively on insanity in the later years. (*DNB*)
[169] *Morison's Diaries*, 18, 19, 21, 27 and 28 January 1824.
[170] Ibid., 27 January 1824.
[171] Morison 1825: 54.
[172] *Morison's Diaries,* 19 December 1823.
[173] Morison 1825: 67.
[174] Morison 1829: 125.
[175] Scull et al. 1996: 140; *Morison's Diaries*, 21 May 1823.

phrenologist.[176] In the following two years Morison's interest developed further: he befriended Spurzheim and attended his lectures in Paris and in London. He obtained phrenological casts to use in the lectures and even ordered a cast of his own head.[177] Moreover, Morison attended several meetings of phrenological societies and the first edition of the *Outlines* contained numerous references to Spurzheim and Gall.

However, Morison's interest in phrenology started to decline when Spurzheim's ideas on insanity came into direct conflict with Esquirol's ideas of mania and monomania, as Morison agreed with the latter. Furthermore, as an evangelical he found phrenological materialism problematic and as a deeply conservative person he did not relish phrenology's ties with political radicalism.[178] The growing amount of physiological evidence against phrenological claims increased Morison's scepticism further. In the later editions of the *Outlines,* he still mentioned Gall and Spurzheim when discussing the anatomy and physiology of the nervous system, but the overall amount of phrenological content decreased dramatically.[179]

Morison's disappointment in phrenology attracted the attention of Scull, MacKenzie and Hervey and the explanation above was based on their excellent account.[180] However, I am even more intrigued by the fact that even in the heyday of Morison's "flirtation with phrenology" he did not teach on it more extensively. I attribute this to Morison's good entrepreneurial sense. He lectured in Edinburgh and, from 1825, in London — the cities with strong phrenological societies and regular lectures and demonstrations by famous phrenologists who conducted their own research and published popular works on the subject.[181] Morison would not be able to compete with them and it would be to his significant disadvantage if he attracted their animosity as a competitor.

Another prominent feature of Morison's teaching was the increasing use of physiognomic illustrations. Although there is some evidence in Morison's diaries that he used visual materials for teaching from the beginning, in 1825 he for the first time made notes on employing casts and drawings during the lectures in Edinburgh.[182] The new edition of the *Outlines,* which came out in 1826, included 13 portraits copied from Esquirol's collection.[183]

---

[176] *Morison's Diaries*, 20–22 January 1823.
[177] Scull et al. 1996: 141.
[178] Ibid: 142–43.
[179] Morison 1829: 18.
[180] Scull et al. 1996: 140–43.
[181] Cooter 1984; Van Wyhe 2004.
[182] *Morison's Diaries*, 7 and 24 November 1825.
[183] Morison 1826: 126–51.

Morison explained that the purpose of the portraits was to "convey an idea of the *moveable* physiognomy in certain species of mental disease."[184] He contended that mental disease left its mark on the face through repetitive movement of facial muscles.[185] Hence, observing the physiognomy of a patient was invaluable for accurate diagnosis. Furthermore, knowledge of physiognomy could help in recognising the earliest signs of mental illness, which was crucial for favourable prognosis.[186] The 1829 edition of the *Outlines* contained 17 plates. This time some of them were portraits of Morison's own patients, which he commissioned for use in lectures and publications.[187] In the preface, the author pledged to improve the following editions with "farther illustrations, as it may be in my power to collect."[188] He made good on his promise and the last edition published in 1848 included 22 plates, mainly commissioned in the early 1840s.[189] Morison constantly added to his collection: he visited asylums bringing his commissioned artists and selected appropriate patients for portraits.[190] Many of the portraits had never been published but it is likely that at least some of them were used during lectures.[191]

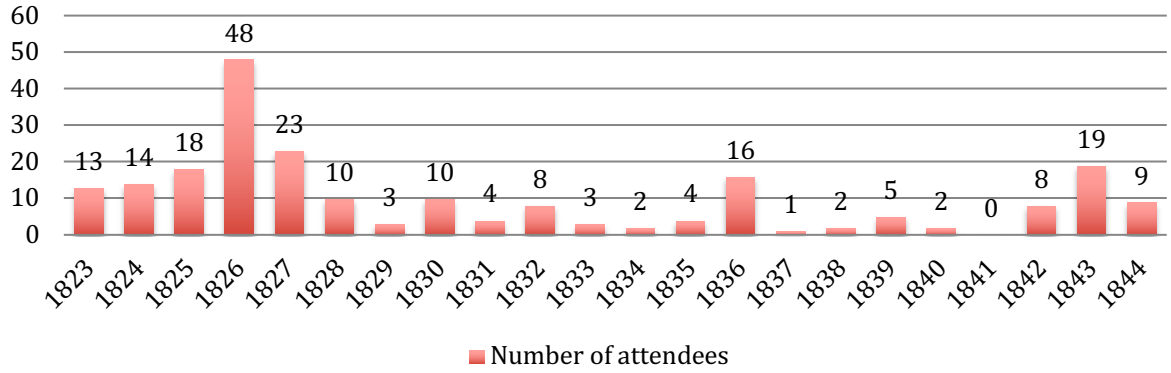
The illustrations in the *Outlines* attracted praise from reviewers and Morison decided to publish a collection of portraits with brief clinical notes on each case as a separate volume. The first edition of *The Physiognomy of Mental Diseases* was published in 1838.[192] It contained 98 portraits and the subsequent editions, published in 1840 and 1843, each had new illustrations added.[193] Although one might suspect that Morison's interest in physiognomy was related to his fascination with phrenology, in fact the *Physiognomy* was inspired by the works of Phillipe Pinel and Étienne Esquirol, both of whom used the observation of facial features and patient portraits for studying and classifying mental disease.[194] Morison also drew on the *Essays on the Anatomy of Expression in Painting* (1806) by Scottish surgeon and physiologist Charles Bell, which attempted to explain the anatomical foundations of the representation of emotions in art through contemporary physiognomic theories.[195] This explains why Morison's interest in physiognomy and its use as a diagnostic and investigative technique remained intact long

[184] Ibid: 125. Emphasis original.
[185] Ibid: 124.
[186] Morison 1838: 1–2.
[187] Morison 1829.
[188] Ibid: 6.
[189] Morison 1848.
[190] For the history of Morison's work with the artists see Beveridge 2018. *Morison's Diaries* contain numerous mentions of this work throughout the 1820s, 1830s and 1840s.
[191] A collection of 249 original drawings is kept at the Royal College of Physicians of Edinburgh: 'Drawings for Alexander Morison's book "The Physiognomy of Mental Diseases"', RCPE, DEP/MOR/3.
[192] Morison 1838. For a detailed history and analysis of the *Physiognomy* see Beveridge 2018; Kearin 2020.
[193] Morison 1838, 1840, 1843.
[194] Kearin 2020: 163, Beveridge 2018: 272, 275–76.
[195] Kearin 2020: 163, Beveridge 2018: 275.

after he abandoned phrenology.[196]

Morison's lectures ran annually from 1823 to 1844 in Edinburgh and from 1825 to 1844 in London. He never succeeded in attaching his lectures to an academic institution but built ties with the Royal College of Physicians of Edinburgh and with several metropolitan asylums. From 1827 Morison offered his London students clinical demonstrations in Hoxton Madhouse and from 1835 he had permission to bring students to the Middlesex Lunatic Asylum in Hanwell.[197] In 1844 Morison stopped teaching in favour of other numerous and more lucrative occupations: serving as a visiting physician to several public and private asylums and as visitor to Surrey private asylums and private practice. His combined annual income at the time was about £1000 and, although the lectures had never become a commercial success on their own, the status and authority they afforded was instrumental in Morison's securing other appointments.[198]

Fig. 1. 1. Attendance at Alexander Morison's lectures (1823-1844)



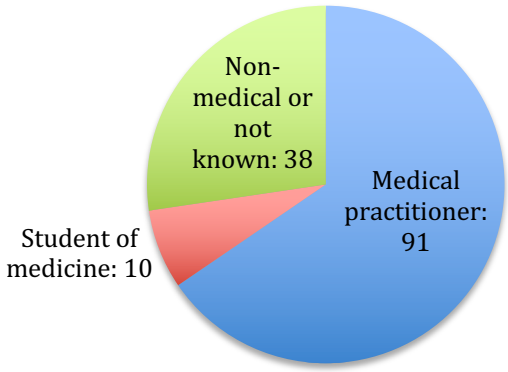
Despite all Morison's efforts the lectures never took off in the way he envisioned when attempting to follow in the steps of famous private medical lecturers of his time: "Grainger, Baillie, Hunter, Fordyce etc."[199] He struggled to attract students and in the first three years of

[196] Beveridge 2018. For a discussion on the relationship between phrenology and physiognomy see Twine 2002. For uses of physiognomy in medicine see Jordanova 1993. On the earlier history of physiognomy in European Culture see M. Porter 2005. By the 1820s it had a long history as a medical technique. On the history of visual media in psychiatry see Sidlauskas 2013; Rawling 2021a, 2021b, 2017; 2011; Bressey 2011; Plessis 2015; Pichel 2016; Green-Lewis 1996: 145-186; Godbey 2000; Gilman 1988; Jackson 1995; Browne 1985; Pearn 2010.
[197] Scull et al. 1996: 138; "Petition of Alexander Morison to the Chairman and Justices of Peace, appointed to superintend the management of the Middlesex County Asylum, at Hanwell", RCPE, SOC/8/1/2 3:6.
[198] Scull et al. 1996: 149.
[199] *Morison's Diaries*, 22 January 1824.

lecturing the number of attendees did not reach twenty per year (see Fig.1.1). His patroness, Harriot Coutts was disappointed with the situation and withdrew her endowment in early 1827. Morison was furious and even intended to take her to court but reconsidered after his influential friends advised him not to do it, so as not to damage his reputation and alienate aristocratic patients.[200] However, the returns from the investment of his subscription fund were sufficient to finance the lectures even when the attendance fees were miniscule.

According to Morison's list of attendance, over the whole period of 21 years, his course was attended by only 139 people.[201] Some of them took the course several times, raising the numbers slightly, but even so most of the years the attendance was very low (see Fig. 1.1.).

Fig. 1.2. Occupations of Morison's Lectures' Attendees (1823-1844)



Although Morison's list might not be entirely accurate, it still provides a useful insight into his audiences. For example, even though the course was developed with the aim to attract medical students, they constituted a minority of attendees, the majority being qualified medical practitioners (see Fig. 1.2). For some of them Morison recorded more specific occupational information: 19 served in the Army and Navy, 8 — in the East India Company and 12 were attached to lunatic asylums. Occupations of the remaining 38 attendees were either non-medical or not mentioned. For example, there were 2 asylum governors, 5 clerics and 3 chemists. Since the course was not officially restricted to medical practitioners, anyone who was interested in insanity could attend. However, the content of the lectures was aimed at

[200] Scull et al. 1996: 139; *Morison's Diaries,* 8 February and 27 March 1827.
[201] "List of gentlemen who have attended Lectures and clinical demonstrations by A. M. from 1823 to 1844", RCPE, SOC/8/1/2 2:26. Hereafter: *List of Attendance.*

people reasonably familiar with medicine and it is not clear how successfully the lay attendees could follow the course or even if they took the whole course or only came to one or two lectures.

The composition of the audience partly explains why the lectures attracted a larger audience in London (84 attendees) than in Edinburgh (only 55). It was not just that London was a larger city, but it was also a popular destination for educational tourism: medical practitioners often went there for a year or two to gain clinical experience and to attend private lectures on medical subjects.[202] Since practitioners looking to expand their knowledge were Morison's primary audience, it stands to reason that the lectures in London were better attended.

There had been two periods of increased interest in Morison's lectures: in 1826 and 1842-1844 (see Fig. 1.1). In 1826 the number of attendees more than doubled, compared to the previous year. This sudden increase was likely because this was the year when Morison's London lectures started in earnest. The first London course being similar to the first one in Edinburgh and serving as a prototype. However, in 1826 Morison clearly made an effort to attract more people. Of the 48 people who attended his course that year 32 did so in London. In Edinburgh the numbers remained on a level: 14 in 1824, 17 in 1825, 16 in 1826. According to Morison's records, 1826 was also the year when several notable physicians came to the lectures in London and expressed their endorsement of the course. For example, John Haslam mentioned it in a speech to the London Medical Society, and A. R. Sutherland called the lectures "able and truly interesting" and remarked their "perspicuity and judicious arrangement".[203] Other notable figures in attendance that year included Spurzheim, one medical officer from each St. Luke's, Bethlem and Hoxton asylums and several fellows of the Royal College of Physicians.

The increase in attendance in 1842–1844 was not as dramatic as in 1826 but is probably explained by a change in the medical labour market rather than successful advertising. One of the reasons why Morison's course remained relatively unpopular was that the market for doctors specialising on treating the insane had not yet been formed. Although the asylum reform created a demand for new knowledge, the opportunities for employment in the lunacy system had remained limited. In 1823 when Morison started lecturing there had only been seven county asylums in England in addition to St. Luke's and Bethlem in London, each

[202] Lawrence 1988; 1996; Loudon 1986; Desmond 1989: 101–92; Bonner 1995: 47, 116; Singer and Holloway 1960.
[203] *List of Attendance.*

employing from one to three medical officers. Hence, with the lack of definite career paths in mental disease treatment, Morison's lectures did not offer enough of a competitive advantage to the prospective attendees. By 1844 the number of county asylums increased to thirteen and some practitioners had anticipated the changes brought about by the 1845 Lunacy Acts, which could explain the rise in attendance.[204]

Even though there was a limited demand for Morison's lectures, it does not mean that there was no demand for other forms of medical instruction on insanity. In the final section of this chapter, we will examine what those forms were and their availability to medical practitioners.

4. Entrepreneurial Expansion: Further Initiatives to Disseminate Medico-Psychological Knowledge

Private lecturers were not the only entrepreneurs of the early nineteenth century knowledge market. Another class of actors who sought to capitalise on the growing demand for scientific and medical knowledge were commercial publishers. At the time the book trade was going through a fundamental transformation both in terms of technological advancements and changes in the organisation of the industry.[205] The rapid mechanisation of book manufacture led to unprecedented cheapening of books and periodicals and extraordinary increase in the production of printed matter. Moreover, the momentous 1774 House of Lords ruling which rejected the booksellers' claim to perpetual copyright caused an upheaval in British commercial publishing. Before 1774, a relatively small group of booksellers owned the majority of copyrights and, in effect, enjoyed a monopoly. The ruling determined that new books could have a maximum of twenty-eight years of copyright protection which meant that many previously privately owned texts became public property.[206]

These changes encouraged the publishers to become more entrepreneurial and look for new markets. The removal of copyright from the expensive editions of standard works allowed for the emergence of anthologies and reprints in cheaper formats, which reached a different kind of readership.[207] On the other hand, many publishers started actively seeking out new works and authors to benefit from the limited copyright protection. To make new publications commercially successful the publishers had to be very sensitive to the readers' demands and to

[204] L. Smith 1999a: 82.
[205] Fyfe 2012; Topham 2000a, 2000b, 2000c, 2009, 2013; Secord 2000: 9–40.
[206] Feather 1988: 67–83; Fyfe 2002, 2012: 19–20.
[207] Topham 2000a; 2000b; Secord 2000: 41–76; Fyfe 2002.

correctly determine the market potential of particular books or periodicals.[208]

The first decades of the nineteenth century were characterised by a rapid increase in specialist scientific and medical print, including medico-psychological publications. As Jonathan Topham argued in a paper on the history of scientific publishing "the same period which witnessed the creation of specialist scientific disciplines, typified by trained cadres of 'experts' and increasingly arcane and technical vocabularies, also saw the potential readership for printed accounts of those sciences increase exponentially."[209] As we have seen in the previous sections, in the beginning of the nineteenth century, mental disease started to consolidate into a medical sub-discipline with its own 'experts'. Moreover, the compulsory certification of people as insane before they could be admitted to madhouses or asylums required regular practitioners to familiarise themselves with mental diseases and current legislation.[210] This rising interest in asylums and medical approaches to insanity made publications on these topics highly marketable and caused the appearance of a flurry of dedicated printed matter.

Hence, medical students and practitioners who wished to learn more about mental diseases, and their treatment and management could do so from the growing body of literature on these issues. For the purposes of clarity, I have separated available materials into five categories and will comment on each one below.

1) Medical treatises

First, there was a number of medical treatises on insanity with the rate of publication continually increasing from the 1790s to the 1830s. Most British works on mental disease published in the late eighteenth century were heavily influenced by the ideas of William Cullen. Although the nineteenth-century practitioners continued to refer reverently to his writings, his clinical methods soon fell out of favour as they did not fit into the new paradigm of "kind treatment" and minimal restraint. Some of the most popular late-eighteenth-century treatises included Thomas Arnold's *Observations on the Nature, Kinds, Causes and Prevention of Insanity, Lunacy and Madness* (1782), John Haslam's *Observations on Insanity* (1798), and William Perfect's *Cases of Insanity, the Epilepsy, Hypohondriacal Affection, Hysteric Passion, and Nervous Disorders, Successfully Treated* (1785) and *Select Cases in the Different Species of Insanity, Lunacy and Madness* (1787).

[208] Topham 2000b: 581–86; Secord 2000: 41-76; Richardson 2008: 60–92; Cox and Mowatt 2020.
[209] Topham 2000b: 561.
[210] Wright 1998.

One of the most important books on insanity during this period was written by Morison's friend and mentor Alexander Crichton. His *An Inquiry into the Nature and Origins of Mental Derangement* came out in 1798. It consisted of two hefty octavo volumes of over 400 pages and presented a systematic analysis of the aetiology, pathology and nosology of mental diseases. Crichton drew on the works of German authors, less well known in Britain, and formulated his own original ideas on the subject. Crichton's book had a great impact on medical psychology in Britain and abroad. It was translated into German the same year it was published in England, into Dutch in 1801 and a synopsis of it was published in French in 1816.[211] Most importantly, Crichton's work had a notable effect on both Philippe Pinel and his protégé Étienne Esquirol who, in their turn, played a significant role in shaping nineteenth-century European approaches to mental illness.[212]

Pinel's work was also well-known and available in Britain. His seminal book *Traité médico-philosophique sur l'aliénation mentale ou la manie* (1800) was translated into English by David Daniel Davis in 1806 under the title *A Treatise on Insanity*. In Britain the initial response to the *Treatise* was not positive, which could have been caused by the animosity between Britain and France at the time and by the low quality of Davis's translation.[213] However, in time, Pinel's ideas caught on amongst his British colleagues, many of whom could read his writings in French and after the end of the Napoleonic wars regularly visited Paris for education and research.[214] By 1814 descriptions of Pinel as "the first enlightened writer who has treated the malady [insanity] as a man of sense and a practical philosopher" became commonplace in British press.[215] He was referred to and revered by most anglophone authors on insanity from the second decade of the nineteenth-century onward.

This brings us to the final influential book on insanity I would like to discuss here — James Cowles Prichard's *A Treatise on Insanity* published in 1835. Prichard spent time in Paris working with Esquirol and it became a formative experience. Prichard's *Treatise* drew heavily on his French colleagues' work, most of it not yet translated into English. For example, he cited the second revised edition of Pinel's *Traité médico-philosophique* and Esquirol's articles in French, which introduced many British medical practitioners to the Frenchmen's ideas.[216] Moreover, in his treatise Prichard put forward his own theory of moral insanity, which built on

[211] D. Weiner 1991: 395–96.
[212] D. Weiner 1991.
[213] K. M. Jones 2019: 57; D. Weiner: 1991: 355–64; 2000.
[214] K. M. Jones 2019: 49–62.
[215] *Critical Review, or, Annals of Literature,* 5 (1814): 15.
[216] K. M. Jones 2019: 63–71.

the foundations laid by Pinel. Prichard's book quickly became a classic and occupied this position for decades. Its influence further increased after Prichard became a member of the first Lunacy Commission, an official body to oversee lunatic asylums established in 1845.[217]

In addition to all these and other books on insanity published between 1780s and 1830s, British medical practitioners had access to older works and books in foreign languages. For example, Alexander Morison in his diaries mentioned reading about insanity in French, German and Latin.

2) Medical periodicals

Another source of medical information on insanity was the rapidly expanding medical press. "The birth of British medical journals" is commonly dated to the turn of the nineteenth century.[218] Although by 1800 a considerable medical press had already existed, only a few publications survived past a couple of years. However, in the early nineteenth century a specific journal format began to emerge with "a core of cases and clinical materials, spiced with some news, copious book reviewing and a dash of correspondence," which became the standard of the nineteenth-century medical periodical in Britain.[219]

Just like the production of books, publication of medical journals was in part shaped by the industrialisation of print.[220] The manufacture of periodicals became cheaper and faster and the competition was steep, with an average of three new medical titles being released annually in the first half of the century, with a remarkable period between 1828 and 1839 when the rate rose to over four titles per year.[221] In this environment over 75% of medical journals which debuted between 1800 and 1840 folded within five years.[222] Hence, to succeed in the crowded market the journal publishers and editors had to be entrepreneurial and respond to the demands of their audiences, including the demand for knowledge about mental disease and asylum practice.

For example, Thomas Wakley took advantage of the technological changes in the print industry and adopted the new format of a cheap weekly publication when he established the *Lancet* in 1823.[223] He also introduced an innovative journalistic style — the new journal was

[217] Ibid: 71–79.
[218] R. Porter 1992: 8.
[219] Ibid.
[220] Dawson and Topham 2020b: 37; Frampton 2020b.
[221] Loudon and Loudon 1992: 49; Bynum and Wilson 1992: 33.
[222] Loudon and Loudon 1992; Bynum and Wilson 1992.
[223] Dawson and Topham 2020b: 43; Frampton 2020b: 441.

lively, critical and highly engaged with the medical politics. The *Lancet* challenged the medical elites, exposed corruption and bad practices and made state-of-the-art medical knowledge available to a wide readership.[224] Wakley's journal quickly became a roaring success: after just a couple of years it sold about four thousand copies each week.[225] It is significant, therefore, that from its inception the *Lancet* regularly printed articles, reviews and correspondence on mental disease and related topics.[226] Furthermore, as the journal was deeply involved in medical politics and encouraged reforms, it also covered the issues surrounding the asylum reform and the debates about the role of medical practitioners in the lunacy system.[227]

As the recent edited volume on the history of the nineteenth-century periodicals demonstrated, scientific and medical journals played a key role in creating and maintaining communities of practitioners.[228] The growing numbers and diversity of medical periodicals in the first half of the nineteenth century reflected the heterogeneity of the profession. The new publications often aligned themselves with specific fractions of medical practitioners. For instance, if the *Lancet* with its fiery rhetoric and explosive content catered to the "politically charged section of the medical profession," the *London Medical Gazette*, founded in 1827, served the interests of more conservative and higher ranking practitioners such as the hospital consultants and governing elites of the royal colleges.[229] The 1830s were characterised by the appearance of new medical periodicals outside of the main centres of medical teaching — London and Edinburgh — and the long-lasting hospital journals, like *Guy's Hospital Reports* (1836–1974).[230] Of course, there also remained more neutral publications which targeted a general medical readership, such as the *Medical and Physical Journal,* the *Medico-Chirurgical Review* and the *British and Foreign Medical Review.*[231]

Regardless of their differences, all these journals shared a purpose: "to promote the 'healing art,' and provide a continuing education for doctors who might have little time or

---

[224] Brown 2014; Dawson and Topham 2020b: 43; Frampton 2020a: 314, 2020b: 439–45; Loudon and Loudon 1992.
[225] Brown 2014; Dawson and Topham 2020b: 43; Frampton 2020a: 314.
[226] See for example:
Articles: *Lancet,* 17 (1832): 650–52; 20 (1833): 330–33; 26 (1836): 43–52; 31 (1838): 448–50.
Reviews: *Lancet*, 8 (1827): 50–58; 9 (1827): 355–57; 9 (1828): 692–95; 14 (1830): 136–40; 643–52.
Correspondence: *Lancet,* 8 (1827): 304–06; 430–31, 432; 505–06, 622–24; 33 (1840): 796–97; 34 (1840): 93–95.
[227] For example: *Lancet*, 8 (1827): 797–98; 10 (1828): 128; 13 (1829): 312; 31 (1839): 667–68; 35 (1840): 199–200.
[228] Dawson et al. 2020.
[229] Desmond 1989: 15–16; Frampton 2020a, 2020b; Dawson and Topham 2020a: 43; Brown 2014.
[230] Dawson and Topham 2020b: 49; Bynum and Wilson 1992: 33; Loudon and Loudon 1992: 49–50.
[231] Desmond 1989: 15–16; Frampton 2020a, 2020b.

money for books."[232] As providers of education, medical periodicals often published not only original articles and clinical cases, but also transcripts of medical lectures. The latter sometimes got them in trouble. For example, Wakley experienced the wrath of his colleagues after he published the lectures of Astley Cooper and John Abernethy without their permission.[233] As we discussed earlier in this chapter, lecturing was an important source of income for medical practitioners and many of them did not wish to print their lectures lest their audience decided to forgo attendance in the lecture theatre.[234] However, with the growing emphasis on clinical training these concerns began to subside. Furthermore, there had been an opportunity to print foreign lectures because it did not interfere with the teachers' financial interests.[235] Hence, the medical journals became an important supplement for medical education for both qualified practitioners and medical students.

The crucial aspect of the medical periodicals for our purposes is that all of them, the differences in audiences and agendas notwithstanding, printed materials on mental disease. And, therefore, medical practitioners of all sorts had at least some access to the news and information about this topic. Moreover, the periodicals confirmed that the nineteenth-century medical community's acceptance of the treatment of insanity as a part of medical practice. There is such a wealth of sources that it would not be possible to examine them all in detail, instead let us look at a few illustrative examples. For instance, every volume of the *Medical and Physical Journal* contained several articles on mental disease, predominantly focused on the descriptions of cases and treatments, and reviewed books on the subject. The leading article of the first issue of the *London Medical Gazette* announced that "the state of lunatic asylums generally, and those for the paupers in particular" would be one of the "topics of particular interest" to be discussed in the periodical.[236] They commenced on fulfilling their promise just a few pages later with an article addressing the findings of the Select Committee.[237] The *Edinburgh Medical and Surgical Journal* also printed extensively on the progress of the reform, aspects of diagnosis, treatment and treatment of insanity and recent books about mental disease.[238] As we have already seen, the *Lancet* also published on the issues of mental illness.

---

[232] Loudon and Loudon 1992: 56.
[233] Brown 2014; Frampton 2020a: 314.
[234] R Porter 1992: 12.
[235] See, for example, "Lectures on Diseases of the Brain and Nervous System" by M. Andral delivered in Paris (first lecture *Lancet,* 25 (1835): 473–81).
[236] *London Medical Gazette,* 1 *(*1827): 1.
[237] Ibid: 8–10.
[238] For example:
On asylum reform: Duncan 1808; *Edinburgh Medical and Surgical Journal,* 10 (1814).
On insanity: *Edinburgh Medical and Surgical Journal,* 14 (1818): 351–56; 19 (1823): 538–45; 36 (1831): 112–

Such ubiquity of material on insanity in medical periodicals suggests that it was a conventional aspect of the early-nineteenth-century British medicine.

3) Literature on asylum management and organisation

Not all actors in the asylum reform movement were medical practitioners and the establishment of asylums involved people of many different professions. Sometimes lay people also authored works on the provisions for the insane and the organisation of special institutions for lunatics. On the other hand, some medical practitioners wrote on non-medical aspects of the asylum system for general readership, as much as for their colleagues. This body of literature was also available to medical men and impacted their approach to insanity and its treatment.

Perhaps the most influential of such works was Samuel Tuke's *Description of the Retreat*, discussed earlier in this chapter.[239] He also wrote some shorter pieces on organisation of lunatic asylums, such as *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums* with detailed plans for the West Riding Pauper Lunatic Asylum — a county institution modelled on the Retreat.[240] Andrew Halliday, a physician and an important figure of the reform movement, published several overviews of the situation regarding provisions for the insane in Britain to support the reformers' demands for change, most notably *A General View of the Present State of Lunatics, and Lunatic Asylums in Great Britain and Ireland and in Some Other Kingdoms* (1828). A celebrated Scottish alienist W. A. F. Browne penned his own manifesto *What Asylums Were, Are, and Ought to Be* (1837) based on the lectures he delivered to the lay governors of the Montrose Royal Lunatic Asylum where he served as superintendent. It was a purposefully non-medical book intended to "reach and influence those who administer either by their opinion or by their power to the necessities of the 'poor in spirit'."[241]

There had been many more similar works in the form of books, pamphlets and articles in general and professional press, as their publication was stimulated by the demand for new practical knowledge on the establishment of asylums and by the vigorous campaigning activities of the reformers.

4) Sections in more general medical books, manuals, lectures and encyclopaedias

17; 38 (1832): 11–18, 45–58; 41 (1834): 54–69, 372–86.
Reviews: *Edinburgh Medical and Surgical Journal,* 1 (1808): 228–40; 33 (1830): 159–65; 50 (1836): 242–64; 51 (1839): 215–31.

[239] S. Tuke 1813.
[240] S. Tuke 1815.
[241] Browne 1837: vii.

The growing interest of medical men in insanity and the increasing complexity of lunacy legislation led many authors to cover mental disease as part of other subjects. First of all, there were chapters on insanity in treatises and manuals on forensic medicine because mental derangements had historically been entangled with legal issues. Some of the popular books of this kind were: Samuel Farr's *Elements of Medical Jurisprudence* (1815); George Edward Male's *Elements of Juridical or Forensic Medicine* (1818) and Michael Ryan's *A Manual of Medical Jurisprudence* (1831). A physician John Ayrton Paris and a barrister John Samuel Martin Fonblanque collaborated on a three-volume treatise *Medical Jurisprudence* (1823)*;* they dedicated about 40 pages to insanity and provided a full text of the 1808 County Asylum Act in the appendix. A massive volume of over a thousand pages by American authors Theodric Romeyn Beck and John B. Beck, also titled *Elements of Medical Jurisprudence,* was published in Britain and, hence, was available to British practitioners. It contained a detailed chapter on "mental alienation."[242] Lecture series on forensic medicine also usually covered issues of insanity.[243]

Secondly, mental diseases were often included within general subjects such as theory and practice of physic, *materia medica* and clinical medicine.[244] *The Cyclopaedia of Practical Medicine* in four volumes which came out in the 1830s included multiple articles on insanity written by James Cowles Prichard, John Conolly and A. T. Thompson.[245] Again, insanity was ubiquitous in general medical literature and was mostly treated just as other medical afflictions. It is, therefore, likely that most medical practitioners encountered mental diseases if not during their attendance in medical schools, then in print, even if they did not actively seek this information.

5) Phrenological literature

The final category of publications on mental disease available to medical practitioners in the first half of the nineteenth century was phrenological literature. I have separated it into its own category for two reasons. First, although elements of phrenology were present in many influential works at the time and many medical periodicals published phrenological articles, it still remained an unorthodox and contentious approach.[246] It had a clear theoretical base,

[242] Beck and Beck 1836: 390–481.
[243] For example, see A. T. Thompson's lectures at the University of London (1836, 1837).
[244] For example, Armstrong 1825; Conolly 1828; Sigmond 1837; *Lancet,* 14 (1830): 277–84.
[245] Forbes et. al. 1832–35.
[246] Cooter 1981.

specific clinical practices, its own communities of practitioners and periodical publications, and, thus, it appeared prudent to reflect this separation in my analysis. Secondly, even though many of the phrenologists were medically qualified, starting with the originator of this practice Franz Joseph Gall, medical training was not required to join the ranks of phrenological societies. For example, one of the most ardent promoters of phrenology in Britain was a Scottish lawyer George Combe (1788–1858). He conducted his own phrenological investigations, delivered public lectures all over the country, founded the Edinburgh Phrenological Society in 1820 and authored several influential essays and treatises.[247] Therefore, although the communities of regular medical practitioners and phrenologists overlapped, they were not the same.

Phrenology with its focus on studying the brain to explain human behaviour and personality traits was understandably attractive to medical practitioners interested in insanity. The history of phrenology in Britain and the considerable influence it had on alienists have been explored elsewhere.[248] Here I would just like to point out that phrenological works on insanity were popular amongst the British medical community. Two particular treatises were especially influential: Johann Gaspar Spurzheim's *Observations on the Deranged Manifestations of the Mind or Insanity* (1817) and Andrew Combe's *Observations on Mental Derangement Being an Application of the Principles of Phrenology to the Elucidation of the Causes, Symptoms, Nature, and Treatment of Insanity* (1831). Moreover, medical periodicals printed transcripts of whole lecture courses on phrenology and many medical lecturers included elements of phrenology or a discussion of it in their courses.[249] W. A. F. Browne was a keen supporter of phrenology and relied on it in his medico-psychological practice, he even dedicated his *What Asylums Were, Are, and Ought to Be* to Andrew Combe, so indebted he felt to his work.[250] Finally, phrenologists also started their own periodicals, for example an Edinburgh quarterly *Phrenological Journal and Miscellany* (1823–1847), which were accessible to interested medical men.[251]

The list above is not exhaustive of all the printed sources of knowledge on insanity, but it illustrates the expansion of publications on mental disease in the first decades of the nineteenth century. The amount and availability of printed matter meant that even those

[247] *DNB*.
[248] See, for the history of phrenology: Cooter 1984; Van Wyhe 2004; for influence on alienists: Cooter 1981.
[249] For example, lecture course by Gall in 1823 (first lecture *Weekly Medico-Chirurgical and Philosophical Magazine*, 1 (1823): 241–47), Spurzheim in 1825 (*Lancet*, 4 (1825): 41–46) and by François Broussais in 1836 (*Lancet,* 26 *(*1836): 417–23); lectures within other courses: Abernathy 1825; Conolly 1828; Elliotson 1831.
[250] Browne 1837.
[251] For more on phrenological publications see Cooter 1989.

medical practitioners who could not or did not attend Morison's lectures or have any experience working in an establishment for lunatics, had access to a diverse body of literature on insanity.

Conclusion

The asylum reform movement and the profound transformations in British medicine and print culture created the environment which brought forth the first attempts at medical instruction on insanity in the early nineteenth century.

The campaign to establish rate-supported asylums for insane paupers started at the end of the eighteenth century and continuously gained ground in the first decades of the following century. The reformers achieved the passing of several crucial parliamentary acts which empowered county magistrate to build lunatic asylums. Through the investigations of three Select Committees in 1807, 1815 and 1827 (which was much the same as the 1815) and their own inspections of asylums, the reformers exposed the cruelty and inefficiency of the existing provisions for the insane. Instead, they proposed the creation of the state-regulated system of public county asylums which would operate on the principles of humanity and moral treatment. Although the erection of such asylums did not become compulsory until 1845, several had been opened in the preceding decades on the voluntary basis. The appearance of these new institutions, the increased regulation of the private madhouses and the compulsory certification of insanity created a demand for new knowledge about mental disease and its treatment.

Meeting this demand within the contemporary modes of medical training was a challenge. In the period between 1792 and 1840 British medical education was decentralised, disorganised and largely unregulated. Medical students had to navigate their way to qualification in the rugged terrain of university courses, extra-mural classes, clinical lectures, apprenticeships and attendance at the hospital wards. The high competition within medical profession encouraged entrepreneurship in both medical teachers, who could increase their income and authority by offering a popular course, and medical students, who had to choose the courses which would give them the most advantage over other practitioners. Hence, most innovations in medical education during this period, including instruction on mental disease, relied on the entrepreneurial initiative of individual lecturers and students.

One such entrepreneurial medical practitioner was Alexander Morison who organised the first structured course on mental diseases in Britain. He ran it annually in Edinburgh and in London from 1823 to 1844. Despite Morison's attempts to attach the course to an academic or medical institutions, it remained unaffiliated and was financed by well-invested donations from

wealthy patrons and students' fees. Significantly, Morison's ambitions were primarily pedagogical: he wished to establish himself as a teacher on mental disease, not an original researcher. Hence, he did not advance his own theories but systematised and summarised existing knowledge on the subject and introduced his students to common practices. Although the attendance at Morison's lectures had never been high, he made his teaching activities conspicuous to the rest of medical community and his influential patrons, which helped to shape mental diseases as a separate subject of instruction.

Even though there had been few opportunities for British medical practitioners to attend lectures on mental disease, there was plenty of printed matter on the subject available to them. Entrepreneurial publishers and authors seized the opportunity to capitalise on the demand for knowledge on insanity and offered an abundance of literature on the subject in the form of medical treatises, journal articles, materials on asylum organisation, sections in more general medical publications and phrenological literature. Since medical practitioners were used to taking responsibility for their own learning, they were able to take full advantage of this wealth of printed matter.

Chapter 2. Clinical Teaching: Practical Instruction in the Asylum, 1841–1858

Introduction

For British medical practitioners the early 1840s were crackling with the anticipation of changes, doubly so for the alienists, who actively campaigned for the reforms of both, medicine and of the lunacy law. The anonymous *Lancet* correspondent expressed the mood of the time:

> BUT WHAT ARE THE STUDENTS DOING? Why do they not take measures which must force upon Bethlem and Hanwell the necessity of establishing courses of clinical and other lectures? […] a vast revolution is taking place in the management of asylums, and the qualifications required of the superintendents, and […] in a very few years the professional man, who can produce testimonials of a careful attention to this branch of medical knowledge, will find a path of honourable practice upon him, of which at present, with the want of foresight of youth, he does not calculate.[1]

By the 1840s insanity had become thoroughly "medicalised": it was accepted by both the medical practitioners and the laity as an illness which required medical treatment. The accounts of the progress of the campaign for asylum reform were widely publicised, hence it was reasonable to expect the coming of the new legislation and that it would affirm medical authority over treatment of the insane. At the same time the whole medical profession was gearing up for profound transformations. The mid-century was a time of rapid professionalisation and standardisation of medicine in Britain.[2] The necessity to confirm competency at a particular type of medical work with appropriate credentials, be it surgery, physic, midwifery or asylum practice, was a part of the changes proposed by the reformers. Hence, the *Lancet* correspondent's sentiments were grounded in the widespread expectations of the near future.

In the 1840s and 1850s the conflict between the general practitioners and the corporate elites, which started at the beginning of the century, escalated further.[3] The former were

---

[1] *Lancet,* 37 (1841): 330.
[2] Roberts 2009; Peterson 1978; Waddington 1984; Bynum 1994.
[3] Peterson 1978: 1–39; Butler 1981: 30–61; Digby 1994; Loudon 1986: 223–227; Waddington 1984; Shortt 1983; Burney 2003, 2007.

dissatisfied with their low place in the medical and social hierarchy. They resented the neglect of their interests by the medical corporations and fought for professional respect and financial security. On the other hand, the elites comprised a minority of all medical practitioners and they were threatened by the intense political activity of the much larger group of the rank-and-file of the profession. The old medical corporations fought to preserve their power and privileges. Nevertheless, all sides of the conflict agreed on the necessity of some sort of medical reform.[4] The prolonged deliberations finally led to the landmark Medical Act of 1858. All of these matters deeply affected the alienists who belonged to the general practitioner category of medical men and shared in their dissatisfaction with the elite. Many of the developments in medical psychology and education on insanity at the time followed the larger pattern of changes in the medical profession.

The new lunacy legislation of 1845 had a significant impact on asylum doctors providing additional legal regulations for their practice which did not apply to the rest of medicine.[5] The medico-psychological practice was removed to the asylums from the usual sites of medical practice: the patient's home, a local dispensary or hospital. The peculiar conditions and limitations of alienists' work led their relatively small community to rapidly become organised and consolidated, largely thanks to the foundation and growth of the Association for Medical Officers of Asylums and Hospitals in 1841 and the association's journal in 1853.[6] Consequently, British alienists acquired a distinct collective consciousness as a specific group within the medical profession and discovered ways to campaign for their collective interests. They also sought to ensure that their branch of practice kept pace with the advancements in medicine as a whole.

One of such advancements was the rise of clinical training. It became an important part of certification requirements and reflected the spread of the new clinical medicine developed in post-revolutionary France.[7] The main site for this sort of training was the teaching hospital, preferably a large one with a diversity of cases. This presented a serious problem for the alienists who advocated for the necessity of clinical instruction on insanity, since, as a rule, general hospitals did not admit mental patients. Therefore, most medical students did not encounter mental disease during training and even if a medical school organised a lecture course on mental disease there would be no opportunity for clinical instruction. Hence, clinical

[4] Roberts 2009; Burney 2003, 2007.
[5] Moran 2018; K. Jones 1991a; 1991b; Scull 1993: 165–69; Farquharson 2016; L. Smith 1999b; C. Smith 2007.
[6] Renvoize 1991.
[7] Butler 1981: 46–61; Bonner 1995: 103–41; Avery 2020: 104–52; Bynum 2008: 43–67; Waddington 1973; Holloway 1964; C. Lawrence 1985.

teaching had to take place in asylums, which presented a further set of problems to overcome.

This chapter will engage with these issues and the interconnections between them in detail. The first section will deal with the growing tensions within the medical community and the emergence of professional associations based on the kind or locality of medical practice, such as asylum practice. I will outline the main professional changes and examine their impact on British alienists. The section will present three main developments in mid-nineteenth-century medical psychology: the foundation of the Association for Medical Officers of Asylums and Hospitals for the Insane in 1841, the new lunacy legislation introduced in 1845 and the establishment of alienists' professional periodical, the *Asylum Journal of Mental Science*, in 1853. By defining the boundaries of medical psychology and giving voice to alienists as a group these developments helped to consolidate the asylum practitioners' community and provided the common ground for shaping a professional body of knowledge and standards of practice.

In Section 2, I will explain the rapid increase of importance of clinical instruction in medical education and argue that alienists, as members of the medical profession, considered this form of training essential for education on mental diseases too. I will define what entailed clinical instruction at a teaching hospital and discuss the specific challenges in establishing training in lunatic asylums.

Section 3 will focus on a particular course, which emerged despite the obstacles and enjoyed a moderate level of success. It was taught by John Conolly at the Middlesex Lunatic Asylum in Hanwell and embodied the contemporary standards of effective teaching on insanity: it involved clinical instruction in the asylum wards, where the students had opportunities to interact with the patients; it included lectures which built on the cases encountered in the wards; it was practical; and it offered detailed instruction on implementing the system of non-restraint at a large institution.

Finally, Section 4 will discuss the central role of education in the medical reform of 1858 and the impact it had on asylum practice. One of the key themes of the general practitioners' campaign was the demand for developing standards for medical education, qualification and practice. It was supposed to bring more equality into the profession, improve the social standing of the rank-and-file practitioners and protect the public from incompetence and "quackery". I will demonstrate that the medico-psychological community also sought to standardise their area of practice and present a united discipline to the public. An important step in this direction was the publication of the first textbook on insanity. Unlike other types of

literature on the subject, the textbook offered systematic, comprehensive and consensual knowledge about mental disease, divested of controversy and written to be accessible for beginners. The textbook did not just present the basic facts of medical psychology but, to an extent, created them, which increased the cohesion amongst alienists and indicated the existence of their special expertise to the public.

1. The Consolidation of a Professional Community: The Association for Medical Officers of Asylums and Hospitals for the Insane and Its Role in Sharing Knowledge

Some historians designate 1841 as the birth year of British psychiatry[8]. Even those, who do not go that far agree that it marked an important milestone in the development of that branch of medicine — the foundation of the first professional association for British asylum practitioners. The Association for Medical Officers of Asylums and Hospitals for the Insane (AMOAHI), as it was called, became the focal point of the activities of the medical practitioners employed in public and private asylums. If at the time of the AMOHI's commencement the asylum system had not yet grown particularly large, with the passing of the new lunacy legislation in 1845 which compelled all counties to erect rate-supported institutions for pauper lunatics the system started rapidly expanding. Consequently, the number of medical practitioners within the system was growing proportionately. Moreover, further complication of laws about insanity and public scrutiny over the asylum practices brought about by the efforts of the lunacy reform movement, increased the asylum practitioners' need for community and representation. In this section we will examine the drive for professionalisation and the tensions within the ranks of medical practitioners, the place of "mad-doctors" within the medical profession and the effect of the AMOAHI and new lunacy legislation on the consolidation of the British community of asylum practitioners.

As discussed in the previous chapter, in the first half of the nineteenth-century British medical profession was undergoing a profound transformation. By the 1840s the earlier corporate distinction between physicians, surgeons and apothecaries had given way to the new division between the freshly emerged category of general practitioners and the hospital consultants.[9] The consultants constituted the elite of the profession: a minority of physicians and surgeons with the highest salary and social standing. They held prominent positions at

[8] For example, Berrios and Freeman 1991; Freeman and Berrios 1996.
[9] Loudon 1986: 225–27; Peterson 1978: 5–39; Butler 1981: 30–61; Waddington 1984: 29–52.

metropolitan teaching hospitals where they taught, engaged in medical research and became acquainted with the wealthy, often aristocratic, lay governors of their institutions.[10] The social connections they acquired were especially important because having affluent patrons was essential for launching a lucrative private practice and gaining political influence.[11] Meanwhile, the rank-and-file of the profession consisted of the general practitioners who provided about 90 per cent of all qualified medical services.[12] Most general practitioners had significantly more modest incomes than the consultants and they often struggled to earn a living.[13] They had a lower social standing and their association with trade, coming from being licensed by the Society of Apothecaries and a popular image of them squabbling for clients, condemned them to being seen as second-class practitioners.[14] The majority of asylum medical officers belonged to the category of general practitioners: they practiced both surgery and physic, were moderately paid and did not hold prestigious positions in teaching hospitals. Furthermore, most asylums were situated in remote areas, therefore medical men working there were geographically separated from the centres of medical learning and power. In addition to this, mental institutions, especially private ones, were still tainted by association with the 'trade in lunacy' and the reports of abuses, preventing alienists from enjoying the social privileges afforded to more 'gentlemanly' branches of the medical profession.[15]

The majority of general practitioners were dissatisfied with their inferior place in the hierarchy and loathed the London corporations who represented only the interests of the metropolitan elite.[16] For example, Thomas Wakley with his characteristic ferocious eloquence called the leaders of the London Royal Colleges "crafty, intriguing, corrupt, avaricious, cowardly, plundering, rapacious, soul-betraying, dirty-minded, BATS" and then went on to caution the "numerous youngsters in the profession" of the repulsive character and behaviour of these creatures.[17] Perhaps, even those amongst the *Lancet*'s 4000 weekly readers who shared Wakley's sentiments, would not pass on a chance to join the deplorable elites. However, this was easier said than done. Simply becoming licensed by one of the corporations did not endow

[10] Although the elite practitioners were mainly concentrated in London, this division existed outside of the metropolitan area too but had less to do with hospital employment and more with tending to rich influential clients and gaining prominence though them. Peterson 1978: 12–16.
[11] Digby 1994: 105–93; Waddington 1984: 29–52.
[12] Loudon 1986: 223–27; Peterson 1978: 16–30; Oppenheim 1991: 18–19; Digby 1994: 135–70; Waddington 1984: 9–28.
[13] Loudon 1986: 249–65; Digby 1994: 135–70; Tomkins 2017: 34–75.
[14] Waddington 1984: 29–52; Loudon 1986: 189–207; Peterson 1978: 16–30.
[15] L. Smith 2020; Scull 1993: 232–43; Turner 1991.
[16] Loudon 1986: 189–207; Brown 2014; Peterson 1978: 16–30; Waddington 1984: 29–52.
[17] *Lancet,* 17 (1831): 2.

a practitioner with any power or respect within it. For instance, at the Royal College of Surgeons ordinary members were not even allowed to enter the College through the front door or dine with the fellows.[18] Hence, the disenfranchised ordinary medical men had to find other ways to obtain more control over their profession.

As Wakley pointed out in another piece, the disorganisation and heterogeneity of the medical profession played into the hands of medical corporations and helped them maintain their power:

> the monopolists of their respective corporations have exulted at the continuance of the disorder which has rendered them strong by making their enemies weak, and thus they have been enabled to support their system of plunder, intrigue, and favouritism.[19]

As there was power in numbers, the rank-and-file practitioners began to organise into their own associations. Some of these associations aimed to represent the interests of provincial medical men (as a whole or at a particular locality), others only allowed general practitioners to join (specifically excluding consultants from membership), and some were based on certain types of employment and issues related to it (for example, Poor Law Medical Officers and Army and Navy doctors formed their own organisations).[20] Such associations fostered professional cohesion and advocated for medical reform on behalf of the groups they represented. Many of the British alienists were members of the Provincial Medical and Surgical Association (PMSA), which emphasised the scientific nature of medicine and encouraged unity and research collaboration between its members.[21] The PMSA portrayed ordinary doctors as highly trained and learned men in order to distance them from a popular image of a provincial practitioner as a mere empiricist, and to draw a sharp boundary between qualified medical specialists and unqualified practitioners.[22] Unqualified practice was a serious problem for the rank-and-file of the medical profession. Private practice was highly competitive even among qualified doctors, and having to share the pool of clients with those whom they disparagingly called ‘quacks’ made the financial situation of many doctors even more precarious, not to

---

[18] Peterson 1978: 16–17.
[19] *Lancet,* 16 (1831): 244–45.
[20] Peterson 1978: 16–17.
[21] In 1852 the date and place of Association for Medical officers of Asylums and Hospitals for the Insane annual meeting was arranged to coincide with the PMSA meeting to ensure better attendance. ‘Medico-Psychological Association Minutes, 1841–1855’, RCPsych, GB 2087 RCPSYCH/A/2. Hereafter: *MPA Minutes, 1841–1855*. 10 July 1852.
[22] Peterson 1978: 24–27. On the identity and struggles of provincial medical practitioners on the first half of the nineteenth century see Brown 2011.

mention the damage to professional reputation caused by it.[23] However, the ruling elites of the Royal Colleges did not share the general practitioners' concern about 'quackery' as it had little effect on their careers.[24] This issue in particular highlighted the rift between the two divisions of medical men in the 1840s and 1850s and demonstrated the need for special associations independent of the corporations that represented the interests of ordinary doctors.

Not belonging to the metropolitan elite, asylum doctors were also affected by unqualified medical practice but of a specific kind — the treatment of insanity by lay people. Even though by 1840 treatment of insanity had become medicalised there still remained private madhouses which were run by people who did not have medical qualifications. Moreover, some of the public asylums built after the 1808 Act did not have resident medical practitioners.[25] Lay superintendents managed these institutions and lay attendants administered treatments there. Even the renowned York Retreat had not acquired a resident medical officer until 1838.[26] Having to share control over care for the insane with unqualified practitioners posed a considerable obstacle on medico-psychologists' way towards gaining professional recognition and respect of the public.[27] To tackle these and other issues specific to medical care for the insane British alienists formed their own association, inspired by the example of the PMSA and other organisations based on specific medical employment.

The Association for Medical Officers of Asylums and Hospitals for the Insane was formed in 1841. It started with a circular sent to 88 medical practitioners who worked at institutions for the insane. The circular's author, Samuel Hitch (1800–1881), Resident Physician at the Gloucester Asylum, invited "medical gentlemen connected with lunatic asylums" to co-operate in establishing a professional association to "communicate more freely the results of their individual experience", "co-operate in collecting statistical information relating to insanity" and "assist each other in improving the treatment of the insane."[28] Initially, Hitch suggested meeting annually at the same time and place as the British Association for the Advancement of Science (BAAS) and, although this proposition was rejected at the preliminary meeting, it suggests that he had a certain professional image in mind.[29] It seems

[23] Loudon 1986: 208–13; Digby 1994: 11–69; Brown 2011.
[24] Peterson 1978: 28–29; Roberts 2009; Loudon 1886: 208–13.
[25] Renvoize 1991; Scull 1993: 232–65; Smith 1999a.
[26] Digby 1985: 107.
[27] Scull 1993: 232–44; Oppenheim 1991: 21–34. For a detailed analysis of the interplay between lay and medical power in asylums at the time see, for example, Suzuki 1995; Smith 1999a; Ellis 2001, 2006, 2008; Digby 1985; Forsythe et al. 1999.
[28] *MPA Minutes, 1841–1855*. 19 June 1841.
[29] In the circular it is misnamed the "British Association for the Cultivation of Science". However, there was no association of that name and the details author provided (for example, the place and time of the meeting) clearly

that Hitch thought of himself, and his fellow alienists as learned men engaged in scientific activity who would attend and present at the BAAS meetings. From the very beginning the new association sought to emphasise the scientific foundations of medical psychology and promote sharing of knowledge and research, directly linking it to improvements in patient care.

Like other medical associations of the time, AMOAHI fostered professional cohesion and identity of its members. Hitch's circular and the rules of the Association, which were developed at the preliminary meeting on 27 July 1841 and passed at the first annual meeting on 29 September, clearly demonstrate this. It was established that only medical officers of private and public asylums would be eligible for membership, distinguishing asylum doctors from the medically unqualified asylum superintendents and madhouse proprietors, on the one hand, and from doctors who did not deal with mentally ill patients on a daily basis, on the other.[30] The title of the association and the way the membership requirements were formulated demonstrates the importance of the institution for alienists' professional identity at the time. Unlike in later periods, discussed in the following chapters, in the 1840s and 1850s alienists' identity was primarily based on the site of their employment – the asylum – rather than on a particular branch of medical practice.

The AMOAHI rules also proposed abandoning the terms "lunatic" and "lunatic asylum", except for legal or official purposes, and using "insane person" and "hospital for the insane" instead.[31] Even though the AMOAHI members did not stick to this consistently and in most cases used the words interchangeably, this constituted an attempt at establishing medical discourse, different from the lay and legal terminology. Finally, the rules stated that the members were to be engaged in medical and moral treatment of the insane, and the minutes of the first annual meeting emphasise an important aspect of such treatment:

> [W]ithout pledging themselves to the opinion that *mechanical restraint may not be found occasionally useful in the management of the insane*, the members now present have the greatest satisfaction in according their approbation of, and in proposing a vote of thanks to, those gentlemen who are now engaged in endeavouring to abolish its use *in all cases*.[32]

The practice of non-restraint, although still relatively new in 1841, was swiftly becoming the standard for medical treatment of insanity.[33] It was frequently used as a proof

indicate that Hitch made a mistake in the title and in fact meant BAAS.
[30] *MPA Minutes, 1841–1855*. 29 September 1841.
[31] *MPA Minutes, 1841–1855*. 27 July 1841.
[32] *MPA Minutes, 1841–1855*. 29 September 1841. Original emphasis.
[33] Topp 2018; Shepherd and Wright 2002; Suzuki 1995; L. Smith 1999a: 247–83; Frank 1967.

that medical practitioners needed to be educated about insanity and learn appropriate ways of managing mentally ill patients to be able to avoid resorting to mechanical restraints. In the same way as in 1813 Samuel Tuke blamed cruelty and abuses in madhouses on lack of staff's understanding of insanity, in the 1840s the use of mechanical restraint served as a sign of asylum managers' incompetency[34]. Non-restraint also became a key argument for lunacy reform and played an important role in parliamentary debates leading to the Lunacy Act and County Asylums Act of 1845.[35]

The AMOAHI minutes indicate that, similar to other medical associations, it was expected to represent its members' political interests and advise on legislation regarding lunacy. However, in the first decade of its existence the Association did not do much in this area, apart from contacting Lord Anthony Ashley Cooper (1801–1885), future earl of Shaftesbury and the leader of the parliamentary forces advocating lunacy reform. At the 1843 AMOAHI meeting Dr Hitch, the Secretary of the association, reported that he "had brought the Association under his lordship's notice, and had offered its co-operation, which he [Lord Ashley] had accepted."[36] Indeed, although an account of early history of AMOAHI, optimistically claimed that in 1841 it "seemed fairly launched and its prospects were bright", the Association struggled to attract members to the annual meetings and depended heavily on the energy and initiative of its secretary until the early 1850s.[37] Hence, the AMOAHI, as an organisation, did not have much influence over the parliamentary debates leading to the new lunacy legislation passed in 1845. However, this legislation had a significant effect on medico-psychological practice in Britain.

The 1845 Acts were considered by many to be the pinnacle of the lunacy reformers' efforts of the first half of the nineteenth century. The Acts made the building of the rate-supported county lunatic asylums for paupers compulsory, cementing institutialisation of the insane as the main response to mental illness.[38] The new legislation also emphasised that asylums were the sites of medical treatment rather than merely of isolation; the Acts stated that every asylum, public or private, had to employ a resident medical officer and keep detailed records of admissions, medical care, discharges, deaths, injuries and the use of restraint and

[34] Suzuki 1995; Topp 2018.
[35] Lunacy Act 1845, 8&9 Vict., c. 100; County Asylums Act 1845, 8&9 Vict., c. 126. Hereafter: Lunacy Acts 1845.
[36] *MPA Minutes, 1841–1855*. 1 June 1843.
[37] For early history: Outterson Wood 1896: 246. For attendance at meetings and lack of initiative: Renvoize 1991; Bewley 2008: 10–23.
[38] Scull 1993: 206–12; K. Jones 1991b; Murphy 2003; Forsythe et al. 1999.

seclusion.[39] From 1845 the lunatic institutions and their records had to be regularly inspected by the central Lunacy Commission. It had jurisdiction over the whole country, not just the metropolitan area, as in previous years, and consisted of laymen, lawyers and medical practitioners. The Commissioners visited public and private asylums alike and could deny or withdraw a licence from private asylums if they found cause for it.

The new Lunacy Commission had significantly more power than its predecessor, the Metropolitan Lunacy Commission. For example, they could visit an institution at any time and could demand changes they thought necessary. The Commissioners did not hesitate to exercise these powers from the beginning.[40] Having a lawyer and a doctor present at each inspection ensured that the Commissioners could assess both the maintenance of patients' legal rights and the appropriateness and quality of medical treatment, so that their recommendations and prescriptions were accepted as qualified expert opinions. This function of the Lunacy Commission was especially important for shaping asylum practice in the nineteenth century. The 1845 Acts were, in the words of historian Kathleen Jones, "prescriptive" – "precise, detailed, minimalist, focused on concepts of offence and punishment."[41] They did not establish standards of care and treatment, nor did they clearly define the role of the resident medical officer apart from the meticulous record keeping and having a medical qualification. This was a major disappointment for the asylum doctors who hoped for a more "formative" legislation which would provide a framework for professional medical practice and decision-making in treatment of lunacy.[42] This task fell into the hands of the Lunacy Commission.

After the first two years the Commissioners' reports expanded from short and general eight-page documents to detailed accounts of several hundred pages. These included recommendations and prescriptions to particular asylums as well as general suggestions on treatment and management of insanity. In 1847 the Commissioners' report fully endorsed the system of non-restraint as the standard of good care, claiming that they "have inevitably opposed mechanical restraint, except in extreme cases and have always been glad to find it done away with" where possible.[43] They continued by explaining that the best way to abolish the need for "mechanical coercion" was to practice good classification of patients and employ a sufficient number of competent attendants.[44] This was very important, first, because it

[39] Lunacy Acts 1845.
[40] For example, in the 1847 Report they stated that on two occasions they prescribed a change in diet and on one decided to inspect an asylum at night. *Commissioners in Lunacy Report, 1847–1848*.
[41] K. Jones 1991a: 89.
[42] Ibid.
[43] *Commissioners in Lunacy Report, 1847–1848:* 759.
[44] Ibid: 759.

validated the AMOAHI members' perspective on the issue and officially eliminated the view of restraint as a genuine therapeutic measure that had been widespread in the early decades of nineteenth century. Secondly, it emphasised the importance of the medical officers' diagnostic skills and medical judgement which were considered necessary for good classification and assigning a specific number of attendants to a particular ward. Note, that attendants were also supposed to be competent, which seems to imply some level of training and/or experience.[45] This shows that the Commissioners recognised and supported medical practitioners' claim that specialist medical knowledge of insanity was necessary for providing a high standard of care with minimal use of restraint.

As mentioned earlier, the AMOAHI did not directly influence the legislation in 1845. In fact, the Association struggled to keep up annual meetings and they were cancelled in 1845–1846 and 1848–1850. It also had a very short membership list – only 31 members in 1849 – which made it difficult to ensure sufficient attendance at the annual meetings.[46] The number of attendees had not exceeded twenty, including visitors, before 1851. Although the acquisition and dissemination of medical knowledge about insanity were on the list of the AMOAHI's objectives from the very beginning it could not effectively achieve them in the 1840s. Some papers were read and demonstrations carried out at the annual meetings but the low attendance rate prevented their contents from becoming widely known. While there was talk of publishing some of them at the expense of the Association, it did not happen.

The AMOAHI's condition improved in the 1850s. 1853 saw two important developments which deeply affected British alienists' community. First, the Lunacy Commissioners in their annual report made another recommendation crucial for the professionalisation of medical treatment of insanity and the establishment of standards of practice – they finally defined the role of a medical superintendent. The Commissioners' report specified that he should have both surgical and apothecary qualifications, in other words, be a general practitioner. It was recommended that the medical superintendent should reside at the asylum and be precluded from private practice in order to devote all his time to work at the asylum, but most importantly "he should have *paramount* Authority at the Asylum".[47] For his duties, the Commissioners suggested, he should be "liberally remunerated" and provided with

[45] On the role of attendants in implementing the non-restraint system see Suzuki 1995; Topp 2018; York 2012; Frank 1967; L. Smith 1999a: 247–83.
[46] *MPA Minutes 1841–1855*, 1 February 1849.
[47] *Commissioners in Lunacy Report*, *1852–53*: 113. Original emphasis. The prohibition of private practice did not apply to private asylums and caused some friction between public and private asylum medical officers. Renvoize 1991. Original capitalisation.

free board and accommodation.[48] They discouraged employing salaried visiting physicians, although they empowered the resident medical officer to call for surgical or medical advice in difficult cases at the expense of the institution. This cemented medical authority over treatment of the insane. However, according to this description, the position of medical superintendent did not require any special training concerning insanity – only a general medical qualification and "high Character and Experience".[49]

The second development of 1853 was the launch of the AMOAHI's own specialist periodical. It was, in part, aimed to remedy this lack of knowledge about mental disease. Asylum medical officers often complained about the absence of medico-psychological training at medical schools and, consequently, the ineptitude of many licensed medical practitioners when it came to diagnosing and treating insanity.[50] Naturally, AMOAHI members never accused each other of incompetence — after all, it was a professional organisation – but their discussions during the meetings indicated an unsatisfied need for practical information about insanity and asylum management. The new publication was called the *Asylum Journal of Mental Science*. It was not the first medical periodical on insanity; Forbes Winslow's *Psychological Medicine and Mental Pathology* had been published since 1848 and was the first successful specialised medical periodical in Britain.[51] However, unlike the newly founded *Asylum Journal*, Winslow's publication was highly theoretical and quite hostile to public asylum officers.[52] Nevertheless, the demand for literature on insanity was high enough to keep both journals in print for 30 years.[53] The first editor of the *Asylum Journal*, John Charles Bucknill (1817–1897), the superintendent of the Devon Lunatic Asylum, chose a strategy different from Winslow's: he strove to serve the interests of both private and public asylum doctors and prioritised practical topics.[54] One of the very practical interests the two groups had in common was the improvement of education — both, initial training of medical students and further education of excising medical officers. Hence, in the first decade of its existence the *Asylum Journal* published many accessible lectures on the theory and practice of medical treatment of insanity.

Increasing number of asylums and patients within each asylum after the 1845 Acts led to the proportionate growth in the alienists' ranks. As its founders hoped, the new journal

[48] *Commissioners in Lunacy Report, 1852–53*: 113.
[49] Ibid. Original capitalisation.
[50] See, for example, Conolly 1830, 1858; Maudsley 1866; Clark 1869.
[51] Dawson and Topham 2020b: 50.
[52] M. Shepherd 1992: 192; Scull et al. 1996: 197; Oppenheim 1991: 24.
[53] Dawson and Topham 2020b: 50.
[54] M. Shepherd 1992; Beveridge 1998; Scull et al. 1996: 195–97.

revitalised the AMOAHI and the membership reached 121 in 1854, just a year after the publication's launch. The annual meeting in 1854 marked a turning point in the history of the Association; the meetings did not get cancelled thereafter and were always well attended. Rules and procedures were amended to reflect the new and improved state of the organisation. For example, instead of appointing a chairman at the annual meeting, the AMOAHI instituted a more prestigious post of President for the whole year and a permanent Parliamentary Committee was set up to advise on new legislation and advocate for the interests of the profession.[55] From 1854 all the annual meetings had the same general format and the minutes with detailed accounts of all proceedings were published in the *Asylum Journal.*

With the establishment of its journal the AMOAHI acquired a voice which carried beyond the circle of its members. It demonstrated to the alienists themselves and to the larger publics the main principles of the mid-nineteenth-century medico-psychological theory and practice, developed through discussions at the meetings, in print and in correspondence. The cornerstone of the alienists' professional identity was that insanity was an illness which had a physical cause, which therefore required medical treatment by a qualified professional. However, to treat and diagnose mental diseases successfully a medical practitioner had to have specialised knowledge beyond the scope of general medicine. Institutionalisation at an asylum was considered a necessary part of treatment because the asylum as a whole, including its architectural design, was supposed to be curative.[56] The AMOAHI members agreed that cruelty and overuse of mechanical restraint were unacceptable and unprofessional and that resorting to such practices pointed to the incompetence of the medical officer rather than therapeutic necessity. The minutes of the members' discussions reflect their certainty that effective medical treatments would be found through medical research and the collection of accurate statistical data, and that any meaningful improvements in the care of the insane would necessarily include improvements in education and training. The *Asylum Journal*, although an invaluable instrument for sharing knowledge, did not present it in a systematic way and could not fully remedy the lack of structured instruction and guided clinical experience. Thus, British alienists did not rest on their laurels and exerted significant efforts in establishing proper training on mental disease.

---

[55] *AJMS*, 1 (1855), 83–88.
[56] L. Smith 1999a; Scull 1993: 115–73; Edgington 2007; Digby 1985; Fennelly 2014; Hickman 2009; Franklin 2002.

2. The Rise of Clinical Teaching

Just as earlier in the century, between 1841 and 1858 medico-psychological instruction had to carve a place for itself within the larger system of medical education. Despite the activities of the medical reformers in the 1840s and 1850s, medical training remained highly disorganised and the standards of the numerous licensing bodies continued to vary. However, the landscape of educational institutions had changed. If at the turn of the century most teaching took place at the numerous private medical and anatomical schools, by the 1840s their importance had been eclipsed by teaching hospitals.[57] The rise in popularity of this new site of teaching was connected to the growing demand for the new format of teaching — clinical instruction. "There is no practice like hospital-practice for training the student into the practitioner" was the pedagogical motto of the period.[58] There had been several reasons for this shift in pedagogy which affected all branches of medicine and contemporary ideas of appropriate education for medical practitioners. In this section we will examine these reasons and explain how they affected teaching on insanity.

Why did teaching hospitals become so popular? First of all, the change in the pedagogy reflected the wider change in medicine: a new type of clinical medicine originated in post-revolutionary France and was soon appropriated by British medical men. It rested on a tripartite foundation of physical diagnosis, anatomico-clinical correlation and the development of nosological categories and therapies based on the data from large numbers of cases.[59] All three of these foundations required highly developed clinical skills from the practitioners. The techniques of physical diagnosis, such as palpation, percussion and especially the recently developed stethoscopy, could not have been effectively learnt in a library or lecture room, they required first-hand guided experience with patients.[60] A Westminster Hospital lecturer described the importance of clinical teaching as an instrument of acquiring not only knowledge but of confidence and independent judgement:

> By a careful and persevering attention to clinical study, the student soon acquires a steady confidence in the knowledge he obtains, and a firm reliance of the *means* by which he has acquired it; for he quickly finds, that what he notes, observes, and records for himself, becomes sound, practical, useful knowledge, applicable at all times. […] A little help from those more experienced clears the obscurity of his path, and directs the student by a quicker, a shorter, perhaps an easier

[57] Butler 1981: 48; Peterson 1978: 12–16; Bonner 1995: 170–73; Holloway 1964.
[58] Bainbrigge 1845: 717.
[59] Bynum 2008: 46; Avery 2020: 12–17; Waddington 1973.
[60] Avery 2020: 104–52; Bynum 2008: 46–47; Butler 1981: 50–51; Bonner 1995: 119–23.

> route to those objects most worthy of his attention.[61]

University College Hospital even established a separate chair for clinical medicine. The professor was responsible for "the duties of practically teaching the stethoscope, the art of percussion, the method of examining the urine, etc., in addition to pointing out the general phenomena of each case."[62] For the purposes of acquiring practical skills, these techniques were taught to small groups of students at the bedside with an opportunity for the students to examine the patients for themselves.[63]

The ability to correctly observe and identify physical signs of illness was also essential for the practice of anatomico-clinical correlation: connecting the symptoms of a living patient to the pathological findings of the post-mortem examination after the patient's death.[64] The hospital schools were uniquely suited for this practice too, since there were frequent opportunities to observe the course of a disease in a clinical setting and then perform a dissection on a body of the same person. An article on London hospital schools published in 1851 pointed to this as a great advantage of instruction at University College Hospital:

> the cases, while still at hospital, particularly those likely to have fatal termination, are minutely considered, so that the students may have frequent opportunities of comparing symptoms and *post-mortem* lesions, and of observing how far the grounds for the diagnosis have been found valid.[65]

Other sites of medical study could not offer the same advantage: during their apprenticeships students could become adept at physical diagnosis, if their instructor was competent at it, but would not usually be able to perform post-mortems; private anatomical schools provided cadavers for dissection but did not teach clinical skills at the bedside.[66]

Finally, the third key principle of the new clinical medicine demanded collecting data from large numbers of cases to explicate diagnostic criteria and ascertain therapeutic effectiveness of different treatments.[67] A large teaching hospital could furnish students with much greater numbers of cases than an apprenticeship even at a busy private practice. As a Liverpool lecturer on clinical surgery, W. H. Bainbrigge, explained to his audience: "The hospital is the true school for the student, and of all hospitals one that we naturally see crowded

---

[61] Basham 1846: 509. Original emphasis.
[62] Cormack and Semple 1851: 84.
[63] Ibid: 88.
[64] Avery 2020: 12–17; Bynum 2008: 53–59.
[65] Cormack and Semple 1851: 88. Emphasis original.
[66] Butler 1981: 50–51; Bonner 1995: 170–75.
[67] Bynum 2008: 59–61; Avery 2020: 12–17; Bonner 1995: 170–75.

with accidents must be considered the most efficient."[68] In addition to the current patients, the students at teaching hospitals had access to the accumulated past medical records from a number of different practitioners.[69]

The second reason for the rise of hospital teaching was the change in medical licensing requirements which followed the spread of the new medical approach. Apprenticeships were rapidly becoming an out-dated way of training and their place was taken by clinical experience at a "public hospital, infirmary or dispensary".[70] The main qualification for general practitioners, the LSA, still required a long period of apprenticeship but it also now demanded six months of hospital or dispensary experience in addition to it. Candidates for the MRCS had to complete a full year of hospital attendance. Both qualifications also required completing lecture courses on clinical subjects.[71] In the 1840s and 1850s, provincial and London medical schools offered such courses to all the students who "walked the wards," therefore allowing them to fulfil all their qualification requirements at one place if they chose to do so.[72] Furthermore, some of the hospital-based medical schools were linked to newly opened universities and colleges, permitting their students to enrol on courses there and even embark on an academic degree, for example, both University College London and King's College had their own teaching hospitals.[73] Therefore, hospital teaching was the most convenient for medical students who wanted to maximise the benefits of training and reduce the cost of it at the same time.

Finally, the change in the structure of the British medical profession, discussed in the previous section, opened new avenues for advancing medical careers. Hospital-based medical schools offered their top students appointments as surgeons' or physicians' clerks, dressers and reporters. Although it was not a licensing requirement, by serving in these roles the students gained valuable clinical experience and professional opportunities through association with influential hospital consultants.[74] Moreover, new appointments to prestigious hospital posts were made from the ranks of the practitioners who proved themselves in junior roles.[75] Hence, for an ambitious student a dressership at a hospital might have been the first step to an

[68] Bainbrigge 1845: 717.
[69] Cormack and Semple 1851: 88.
[70] Butler 1981: 49.
[71] Ibid.
[72] Many students still attended courses at different hospitals or changed schools throughout their course. It was typical for provincial medical students to go to a metropolitan medical school for their final year. Bonner 1995: 218–19.
[73] Butler 1981: 46–55; Bonner 1995: 172–75.
[74] Butler 1981: 51.
[75] Ibid.

illustrious medical career. On the other hand, offering junior posts to students was beneficial for the hospitals as it provided a cheap and enthusiastic labour on the wards.[76]

Like most other medical practitioners in the 1840s, asylum doctors considered clinical training the best way to prepare students for medical practice. They also thought that anatomico-clinical correlation and observation of a large number of cases were effective medical research strategies and would help in the development of cure for insanity, just as they helped in other areas of medicine. So, naturally, some of the asylum practitioners advocated for adoption of clinical instruction on mental disease, however there had been several special challenges to its organisation.[77] The first of them was that it was still very difficult to convince the licensing bodies and academic authorities of the importance of teaching medical students about insanity.[78] John Webster, a physician and one of Bethlem's governors, in 1842 lamented that "even the subject of insanity, does not form an essential part of the stipulated courses of lectures, required by the various licensing medical corporations."[79] According to the journal of the PMSA, by 1853, the situation had not changed much; instruction on mental diseases remained voluntary and difficult to access, and the majority of general practitioners had no special training on the subject.[80] Moreover, mental patients were not admitted to the majority of teaching hospitals, which effectively made clinical instruction on insanity impossible there.[81] Although alienists made several attempts to persuade teaching hospitals to accept a small number of lunatics into the wards or establish an outpatient clinic, they did not succeed.[82] At a time when cure rates of mental patients were low the hospital governors did not want to find themselves with incurable patients occupying beds in their wards for years. Moreover, lunatics required special care and additional attendants to watch over them. If a general teaching hospital decided to accept mental patients, they would have to comply with all the rules of appropriate treatment and care set out by the 1845 Lunacy Acts and the Lunacy Commission. The hospital would also have to submit to regular inspections and comply with the requirements for record keeping.[83] Furthermore, treatment at a general hospital was not only considered troublesome for the hospital staff, it was also regarded as detrimental to the patients themselves because the special conditions of an asylum were supposed to be

[76] Ibid.
[77] For example: Webster 1842: 12–13; *Provincial Medical Journal and Retrospect of the Medical Sciences*, 4 (1842): 354–56, 372–74; *Association Medical Journal,* 1 (1853): 27–28.
[78] Clark 1869: 55–65; Maudsley 1866: 170; Oppenheim 1991: 22–23.
[79] Webster 1842: 6.
[80] *Association Medical Journal,* 1 (1853): 27–28.
[81] Bynum 2008: 63; Lewis 1967; Crammer 1996.
[82] Scull et al. 1996: 52–53.
[83] For an example of how inconvenient lunatics were for hospital authorities see Hunter and Greenberg 1956.

therapeutic in themselves.[84]

Given the above factors, if clinical teaching on mental diseases was to be established at all, it had to be at an asylum. This course of action, however, presented its own difficulties. The provincial asylums where purposefully located at a distance from the cities, often in rural areas, so the logistics of taking students there on a regular basis were challenging. Furthermore, the governors were wary of allowing groups of students to walk the wards of the asylums, worried that it would harm the patients.[85] Similarly to the earlier resistance of lay governors of charity hospitals, some lay asylum stakeholders were concerned that the original function of the institution — the treatment of the patients — might become subservient to the new function of education.[86] Additionally, there still remained lingering memories of the distasteful practice of the time before the lunacy reform when some of the madhouses charged money for showing lunatics to the public as entertainment.[87] The idea of clinical visits might have reminded the governors of that. Finally, even if the logistics of the visit were worked out and the governors convinced, asylums often did not have enough medical staff to carry out the teaching. A resident superintendent often was the only medically qualified person in an institution with hundreds of patients. Even though the Lunacy Commission recommended employing assistants at large asylums, not all institutions followed that advice and, where they did, often it still did not free enough time and resources for regular teaching.[88] However, despite these challenges a few clinical courses were successfully organised. The most notable one was taught by John Conolly at the Middlesex Lunatic Asylum in Hanwell.

3. Clinical Teaching on Mental Diseases: John Conolly

With the lunacy reform in full swing and the growing pressure from some sections of the medical profession to provide opportunities for clinical instruction on insanity some lunatic asylums opened their doors to a limited number of students. Both, St Luke's and Bethlem allowed clinical visits in the 1840s but the most comprehensive and innovative course of instruction started at the Middlesex County Lunatic Asylum at Hanwell under the superintendence of John Conolly. Just like the courses on clinical medicine at the teaching hospitals, the instruction at Hanwell consisted of walking the wards, regular lectures which

[84] *Association Medical Journal,* 1 (1853): 27; Scull 1993: 115–73; Digby 1985: 37–42; Edgington 2007; Hickman 2009; Fennelly 2014.
[85] Webster 1842: 15–19; *Provincial Medical Journal and Retrospect of the Medical Sciences*, 4 (1842): 355.
[86] Bonner 1995: 173.
[87] Scull 1993; Shorter 1997; L. Smith 1999a.
[88] On the commissioners' recommendation see *Commissioners in Lunacy Report, 1852–53*: 113. On the situation in the asylums see Maudsley 1866; Clark 1869; Crammer 1996.

built on the cases observed by students and opportunities to engage with patients. Moreover, it was the first course to teach students the operation of an asylum following the practice of non-restraint. This section will offer some biographical information on John Conolly to demonstrate that he was deeply involved in the general medical community and examine his course of instruction at Hanwell.

John Conolly was born in 1794 in Lincolnshire to a poor but respectable family.[89] He decided to study medicine in his early twenties after an attempt at a military career had not worked out. Already having a wife and a child to support, Conolly settled on medicine as an acceptable gentlemanly way to earn a living and obtained his MD qualification in Edinburgh in 1821.[90] Although his interest in mental diseases started during his university years — he wrote his MD thesis on insanity — after graduation Conolly did not seek an asylum position.[91] Instead he tried to establish a private general practice. It had taken him several attempts before he finally settled down in Stratford-upon-Avon where he managed to earn enough to support his family. "Being a reformer by nature and a hearty liberal in politics" Conolly was actively involved in the town's affairs: he served as an alderman and was the mayor twice.[92] He also maintained his interest in mental diseases by securing an appointment as a medical visitor to madhouses in Warwickshire.[93] Unfortunately, even with the salaries from all these public positions to supplement the income from his medical practice Conolly was far from being wealthy and his career — far from illustrious.[94]

In 1827 it seemed like Conolly's lot would change. He was appointed Professor of the Nature and Treatment of Diseases at the newly established University College London (UCL). UCL governors modelled their institution on Scottish universities, which, unlike many metropolitan medical schools, offered a full medical curriculum to students and, unlike Oxford and Cambridge, provided practical clinical education.[95] The teaching staff consisted mainly of young ambitious doctors educated in Scotland or abroad, who were willing to work for a relatively moderate salary.[96] Conolly hoped that this position would allow him to enter the

---

[89] Maudsley 1866; Clark 1869.
[90] Scull et al. 1996.
[91] Conolly's thesis was titled *"De statu mentis in insania et melancholia"* ("The state of mania and melancholia"). Scull et al. 1996: 50; Hunter and Macalpine 1963: 806.
[92] Maudsley 1866: 164.
[93] Clark 1869: 41; Leigh 1961: 220; Scull, et al. 1996: 51.
[94] In all his years in Stratford Conolly's income never exceeded £400 per annum. Scull et al. 1996: 51; Leigh 1961: 217.
[95] Butler 1981: 5–11; Scull et al. 1996: 52; Desmond 1989: 33–41. For the history of UCL and its medical school see Merrington 1976.
[96] Scull et al. 1996: 52–60; Desmond 1989: 33–41, 83–84.

metropolitan medical elite and establish a lucrative private practice in London. He started preparing for his lectures fourteen months in advance and even went to Paris to acquire material for teaching.[97]

Conolly delivered the inaugural lecture of his course on the nature and treatment of diseases on 2 October 1828 and promised to "dwell somewhat more fully on Mental Disorders" and "to afford opportunities to the student […] to become familiar with the diversified aspects of this alarming malady" in his course on practical medicine saying that it would stimulate medical research in that area and improve treatment of lunatics.[98] Conolly also attempted to organise a separate clinical course on insanity at UCL in cooperation with one of the London asylums but the governors, who at first seemed to encourage him, soon rejected the idea.[99] The reason for the rejection might have been the result of Alexander Morison's scheming, since he was trying to promote his own course on mental disease at the same time and, unlike Conolly, was well connected.[100] Although Conolly was disappointed, he did not entirely abandon the idea of introducing more doctors to medical psychology. In 1830 he published *An Inquiry Concerning the Indications of Insanity,* in which he argued that each lunatic asylum should become "a Clinical school, in which, under certain restrictions, medical students might prepare themselves for their future duties to the insane."[101]

There were many other disappointments Conolly had to face in London. Students did not enjoy his lectures and he struggled to maintain good attendance.[102] In the first few years of its existence UCL staff were split by many internal conflicts and the excessive involvement and interference of the UCL lay council made teaching more difficult.[103] At the time the new university did not have its own teaching hospital so could not offer prestigious hospital positions to the teaching staff and clinical instruction to students. In addition to these problems at UCL Conolly's private practice did not go well so, instead of improving, in London his financial situation rapidly deteriorated.[104]

In 1830 Conolly resigned from the university and moved back to Warwickshire. His failure in the metropolis deeply humiliated him and the renewed struggle to earn enough to support his family was dispiriting. However, Conolly continued his involvement in the Society

---

[97] Scull et al. 1996: 52–60.
[98] Conolly 1828: 16–17.
[99] Scull et al. 1996: 52; Clark 1869: 8.
[100] Scull et al. 1996: 150; Hunter and Macalpine 1968: 14–15.
[101] Conolly 1830: 7. Original capitalization.
[102] Maudsley 1866; Leigh 1961: 218–19; Scull et al. 1996: 52–60.
[103] Butler 1981: 30–39; Scull et al. 1996: 52–60; Desmond 1989: 92–100.
[104] Scull et al. 1996: 59–60; Leigh 1961: 219.

for the Diffusion of Useful Knowledge, which started when he lived in London, and wrote popular medical texts for them in the 1830s.[105] Together with John Forbes, whom he befriended in the early 1820s, and Alexander Tweedie, Conolly edited *The Cyclopaedia of Practical Medicine* and in 1836 founded the *British and Foreign Medico-Chirurgical Review*.[106] As mentioned in the previous chapter, the encyclopaedia included many articles on insanity written by Conolly himself and by Prichard and Thompson. Finally, and perhaps most importantly, Conolly became one of the founders of the PMSA.[107] Having lost hope of joining the professional elite Conolly started devoting a lot of his time and energy to improving the position of general practitioners.

Finally, in 1839 Conolly was appointed medical superintendent of Middlesex County Lunatic Asylum at Hanwell – the largest and most visible asylum in England. He treated his new position seriously and started preparing for it early. Following the suggestion of the chairman of the Hanwell's magistrates, John Adams, Conolly had visited the Lincoln Asylum on 1 June 1839 to learn the system of non-restraint. [108] Robert Gardiner Hill (1811–1878), the house surgeon of the asylum, was the first to completely abolish mechanical restraint in a lunatic asylum in 1838.[109] He publicized this accomplishment through a public lecture and a pamphlet published in 1839.[110] Historian Akihito Suzuki has argued that the magistrates at Hanwell were highly motivated to establish the non-restraint system at their asylum for their own political goals.[111] They were looking for a medical superintendent who could accomplish this goal quickly.

Conolly did not disappoint. As soon as he commenced his duties, he "determined, that whatever difficulties there might be to encounter, no mechanical restraint should be permitted in the Hanwell asylum."[112] This was a monumental task for an asylum which housed between 800 and 900 patients.[113] Indeed, many of Conolly's colleagues considered the complete abolition of restraint at a large asylum impossible and even dangerous. For example, Alexander Morison, who at the time served as a visiting physician to the Hanwell asylum, was a vocal

[105] Maudsley 1866; Leigh 1961: 219–20; Scull et al. 1996: 63–64; Desmond 1989: 203–05.
[106] Forbes et al. (eds.) 1832–35; Scull et al. 1996: 63–64; Leigh 1961: 220.
[107] *BMJ,* 2 (1881): 952.
[108] Leigh 1961: 222; Scull et al. 1996: 70; Suzuki 1995: 10.
[109] Frank 1967; L. Smith 1999a: 261–66; Suzuki 1995; Topp 2018.
[110] Hill 1839.
[111] Suzuki 1995.
[112] Conolly 1860: 838.
[113] The Lincoln Asylum at the time had only about 100 patients and the abolition of restraint there was gradual, it took several years. Frank 1967.

opponent of non-restraint.[114] He deeply disliked Conolly and felt threatened by his innovations and liberal politics. The conflict between the two physicians escalated and led to Morison's ban from using Hanwell patients for his physiognomical studies. Morison retaliated by petitioning the governors to stop Conolly's attempts to abandon physical restraint.[115] The new superintendent also had some enemies within his institution, notably one of the house surgeons G. P. Button, the asylum chaplain Francis Tebbut and a local vicar Reverend H. S. Trimmer. They collected evidence against Conolly and complained to the governors and the county magistrates.[116] A court case and a debate in the daily press ensued, but, unfortunately for Conolly's opponents, their campaign was defeated and the changes at the asylum continued.

While the debates raged, Conolly continued his course to complete non-restraint and finally in September 1840 he reported to the visiting magistrates that all mechanical restraints had been successfully abolished.[117] From the onset of the experiment the magistrates were impressed with the changes introduced by the new superintendent. Their reports were full of praise for Conolly but even more importantly they showed their approval by the increased funding.[118] In 1839 they approved Conolly's suggestion to hire nine additional attendants for the purposes of substituting "vigilant superintendence for personal restraint" and agreed to introduce a more generous diet for the patients.[119] The magistrates also allowed the superintendent to make alterations to the asylum building and provide extra accommodations to the patients who needed them, which was also a costly enterprise.[120] Soon followed the wider approval of the asylums humane policy. If at first his claims were met with scepticism and even outright hostility from some quarters, the perceived success of the system and its apparent benevolence rapidly attracted powerful allies to Conolly's cause. Thomas Wakley published on the advantages of non-restraint on the pages of the *Lancet* and the *Illustrated London News*, *The Times* and other popular newspapers also sympathetically covered Conolly's activities at Hanwell throughout the 1840s.[121] Celebrated reformers, such as Samuel Tuke and Lord Ashley,

---

[114] Topp 2018; Suzuki 1995; Scull et al. 1996: 150–56.
[115] On the conflict between Conolly and Morison see Scull et al. 1996: 150–52.
[116] Hunter and Macalpine 1968: 25–27; Scull et al. 1996: 150–53.
[117] Conolly 1856: Clark 1869; Leigh 1961.
[118] For more on the relationship between Conolly and the magistrates with regard to non-restraint and motives of all parties, see Suzuki 1995.
[119] Hunter and Macalpine 1968: 28.
[120] Ibid.
[121] See for example:
Lancet, 35 (1841): 772–75; 36 (1841): 207–08; 37 (1842): 545–46; 38 (1842): 552.
General press: *Illustrated London News,* 20 May 1843, p. 5; 6 January 1844, p. 3; 15 January 1848, p. 27; *The Times,* 18 May 1843, p. 7; 12 January 1844, p. 6; *Morning Post,* 6 January 1843, p. 3; 14 December 1844, p. 2; 12 January 1844, p. 2; *Morning Herald,* 18 December 1841, p. 2; *Morning Chronicl*e, 19 January 1843, p. 3; 26 December 1844, p. 3.

officially granted non-restraint their approval and the Duke of Cambridge honoured the asylum with his visit in 1842.[122]

This positive media attention and nationwide approval pleased the governors of the Hanwell Asylum and further strengthened their regard for Conolly.[123] Therefore, when in 1842 he decided to make another attempt to establish clinical teaching on mental disease he secured their permission easily.[124] Conolly's brief time in London equipped him with connections to medical schools which made collaborating with them on organising a course at the asylum much easier. Every year one or two interested students from each of the metropolitan medical schools and teaching hospitals came to learn about insanity at Hanwell.[125] By 1842, when the first session took place, Conolly had become a national celebrity, thanks to the publicity his methods brought, and there were a steady number of medical students and young practitioners who wanted to learn from him. It also helped that the lectures were free of charge and that the asylum was conveniently situated near London and easily accessible.

The groups of up to sixteen students attended instruction on Saturdays for ten to twelve consecutive weeks, typically in the late spring and summer.[126] On arrival they were divided into three smaller groups and taken through the wards by the medical officers.[127] The officers commented on the patients and directed special attention to particular cases, sometimes the students themselves were allowed to interact with the patients, learning to work with the insane.[128] In his lectures Conolly went into much detail describing the proper way to converse with the patients in order to not harm or upset them:[129]

> Every student thus admitted, must guard himself against the mistake of supposing that the insane are indifferent to what passes before them; […] no approach to ridicule of the peculiarities of the insane must be indulged in. But they [the students] must also be careful, even when asking any necessary question, not to excite or disturb the patient. […] Insane persons are, for the most part, equally displeased by levity and austerity. They do not like their real sufferings to be thought

[122] Scull et al. 1996: 68–69. Although Conolly was not the originator of the non-restraint, he quickly outshone Hill in the public eyes. This was partly because Hanwell was a much larger and well-known institution, partly because the magistrates of the asylum were keen to advertise Hanwell as a new model institution: modern, benevolent and efficient. Suzuki 1995.
[123] Scull et al. 1996: 68–69; Hunter and Macalpine 1968: 27–29; Suzuki 1995.
[124] Hunter and Macalpine 1968: 29.
[125] Conolly 1845–46 (45): 357–59; Hunter and Macalpine 1968: 29.
[126] Conolly 1845–46 (45): 357–59; Clark 1869: 57–64; Hunter and Macalpine 1968: 29; [Anon.]," Notes of the clinical lectures on insanity delivered at the Hanwell Asylum in 1848 by Dr Conolly and Dr Hitchman", RCPsych, GB 2087 RCPSYCH/X/1/3. Hereafter: *Notes of the Clinical Lectures, 1848*.
[127] Conolly 1845–46 (45): 357–59; Clark 1869: 57–64.
[128] Ibid.
[129] Conolly 1845–46; *Notes of the Clinical Lectures, 1848*.

> lightly of; they resent any harsh reproof; readily detect a sneer; take umbrage at a cross look; and infallibly distinguish between real and spurious kindness.[130]

"Walking the wards" took about two hours each time, sometimes more, followed by a few hours of lecture, which drew on the cases the students observed.[131] This put considerable demands on the asylum's medical staff, as it required at least three experienced alienists to accompany the students in the wards and at least one to conduct the lecture. On top of this there was the preparation for lectures and organising work to consider. Here, the high status and visibility of Hanwell played an important role. Being proclaimed a model institution and showered with media attention put the asylum under high scrutiny, so the governors made sure that it was well staffed and ran smoothly.[132] Conolly had two assistant medical officers who took part in the teaching course, and, after he resigned from the superintendent's post and became a visiting physician in 1843, he had even more time to devote to teaching.

Conolly published the content of the Hanwell lectures in the *Lancet* as a series of eighteen articles in 1845–46, which, combined with the available student accounts and notes provide a detailed picture of the course.[133] Unlike the lecturers of the previous period, Conolly did not dwell on the fine points of classification of insanity and psychiatric theory. His course focused on practical aspects of patient treatment and asylum management. The students were taught how to take detailed patient histories and keep records, which criteria to use when assigning patients to specific wards and how to create the curative environment. Similarly, to the lectures on clinical medicine at the teaching hospitals, Conolly's teaching put an emphasis on observing the physical signs of disease. In the procedure for examining a new patient, he instructed the students to pay attention to the patient's general appearance and movement; the state of their skin, head, extremities and tongue; the function of their stomach, bowels, kidneys and, for women, their uterus; and the character of their sleep and appetite. The students also were advised to take the patient's pulse and perform auscultation. All of these, in addition to the mental symptoms, had to be recorded and regularly monitored.[134]

During their visits to the wards the student also observed patients with different forms

---

[130] Conolly 1845–46 (45): 357.
[131] Conolly 1845–46 (45): 357–59; Clark 1869: 59; Hunter and Macalpine 1968: 29–30.
[132] Suzuki 1995.
[133] *Notes of the Clinical Lectures, 1848* consists of eight detailed lecture notes and clinical remarks taken by an unidentified student at Hanwell. Clark's *Memoir of the Late John Conolly* (1869) includes memories of some of the students and staff, including a letter by William Gull with his recollections of the course as a student in 1842.
[134] *Notes of the Clinical Lectures, 1848.*

and stages of insanity, learning to apply their clinical judgement to real cases.[135] One of Conolly's students later observed that they "from week to week, saw almost every phase of mental disorder, from acute mania to general paralysis and dementia."[136] The anonymous student whose notes are kept at the archive of the Royal College of Psychiatrists took diligent notes not only of the lectures but of the instruction in the wards. For example, on one of the visits he encountered the following case:

> A curious delusion that he has, consists in a great antipathy to Tories — he says "Tories have such a peculiar smell with them." Sufficient for anyone to detest them. His walls are decorated all over with engravings, but not a single portrait of a Tory is seen.[137]

The same student also made copious notes of other cases of mania, melancholia, dementia and epilepsy. The patients he observed were of different genders, ages (from children to senile persons) and occupations.

Unsurprisingly, the principles of the non-restraint system were at the heart of the course. Conolly taught that mechanical coercion was not just cruel and unnecessary but that it was also medically harmful because it "excited the brain" and exacerbated the patients' symptoms.[138] Furthermore, in his view, proper clinical teaching of medical psychology was only possible when restraint had been abolished "permitting the students to contemplate disorders of the mind in their simplicity, and no longer modified by exasperating treatment."[139] Like Morison, Conolly used the various restraining contraptions as props for his lectures. However, where Morison demonstrated them to students as the tools of the trade and explained when and how to use them, Conolly was only interested in their sensational quality. After abolishing mechanical restraints at his asylum, he carefully collected all the items, counted them and kept the examples of different types of restraints, and then showed them to students and visitors emphasising the obvious inhumanity of their use.[140] There is no record of how exactly the contraptions were presented, but I wonder, if Conolly encouraged students to engage with them physically: feel the weight of the chains in their hands, touch the rough

---

[135] Conolly 1845–46; *Notes of the Clinical Lectures, 1848.*
[136] Clark 1869: 59.
[137] *Notes of the Clinical Lectures, 1848*: 37.
[138] Conolly 1845–46; *Notes of the Clinical Lectures, 1848.*
[139] Conolly 1856: 282.
[140] Hunter and Macalpine 1968: 24. However, Conolly was an active proponent of seclusion as an alternative to physical restraint, he also maintained a strict, almost military discipline at Hanwell and had only superficial personal contact with the patients. For more information on Conolly's approach to non-restraint see Topp 2018, Suzuki 1995.

leather of collars, try on a straitjacket or sit in a restraining chair. Even if he did not, just the sight of these objects would be frightening.

During the course Conolly also frequently pointed out all the adjustments made at Hanwell to keep the patients safe, dressed and clean without restraining them. For example, the floor of the rooms for the epileptic patients was covered with bedding, so if they had a seizure and fell from the bed, they did not hurt themselves.[141] Under the previous superintendent such patients were simply tied to their beds.[142] Conolly also suggested keeping a rocking horse in the airing court:

> [the insane] often when furiously excited, push into the airing court, jump on the rocking horse, and swing themselves to and fro until they are nearly exhausted. They rarely fall off, and when they do, they always hurt themselves as little as possible.[143]

It seems like no detail was too small or too trivial and the students learned more about the management of the institution and the ways to create a curative environment, then about medical theories of insanity or recent research. This was also a typical characteristic of a clinical course aimed at imparting practical knowledge which could not be learned from the books. Conolly claimed that the real encounter with the insane would quickly teach the students to see the insane as patients who needed help rather than dangerous criminals or animals.[144]

The treatments Conolly presented during the course were typical for the 1840s and 1850s. All of them were based on the idea that being in a properly organised asylum in most cases was curative in itself.[145] That meant that the environment at the asylum was of paramount importance for the medical outcomes: "nothing is trifling in a house full of infirm and irritable minds."[146] According to Conolly, the institution had to be safe for the patients and prevent them from harming themselves, but every care needed to be taken to ensure it did not look like "a place of confinement."[147] It was important to clothe and feed patients well and take care of their comfort as much as possible. An asylum had to offer opportunities for work, learning and entertainment, as those were important for recovery and preventing future recurrences of mental illness. "Remedial words" and kindness were the most universal and effective remedies

---

[141] *Notes of the Clinical Lectures, 1848:* 36; Hunter and Macalpine 1968: 24.
[142] Ibid.
[143] *Notes of the Clinical Lectures, 1848*: 38.
[144] Conolly 1845–46 (45): 357–58.
[145] For exceptions see Conolly 1845–46 (47): 453–56.
[146] Conolly 1845–46 (45): 358.
[147] *Notes of the Clinical Lectures, 1848:* 1.

for all types of insanity.[148] Although Conolly discussed the use of different medicines and procedures to treat insanity, he admitted that these were not always effective and lamented the lack of adequate medical research on different treatments. He taught the students "not to torment the patient by much medicine" if its effectiveness was not apparent.[149] Some authors presented this lack of trust in medicine as a sign of his retrogressive views and even incompetence, but other researchers point out that some of the most celebrated Victorian doctors shared Conolly's cautious use of pharmaceutical remedies.[150]

The clinical courses at Hanwell continued for six or seven years and were eventually cancelled because of the strain they put on the asylum's resources.[151] Unfortunately, the lists of students who attended them has not survived but at least one of the attendees is known – William Gull (1816–1890), who took the course in 1842.[152] When asked to comment on the course later in life he wrote that he was impressed with "the novelty of the clinical work and teaching; the new field of facts before us, contrasting with those afforded in the routine of our other hospitals."[153] Although asylum practice did not become his main occupation, Gull was put in charge of the Guy's Hospital lunatic ward in 1843, as a direct result of being the only doctor at Guy's who had had special training on insanity, and in a decade he spent on this post Gull effected many changes based on what he learnt at Hanwell. In his later career he, among other things, wrote on insanity and, as some historians claim, Conolly's teachings profoundly influenced his medical practice as a whole and in time were transmitted to Gull's own students.[154]

The courses at Hanwell did not lead to widespread establishment of clinical teaching on mental disease in Britain. However, there were some other opportunities to learn about insanity available to medical practitioners between 1841 and 1858. As we already know, Morison's lectures in Edinburgh and London continued until 1844. Also, from 1842 St Luke's allowed student visits the wards and the physician there delivered several clinical lectures a year.[155] From 1848 regular courses also started at Bethlem Royal Hospital; they ran twice a

---

[148] Conolly 1845–46 (45): 358.
[149] *Notes of the Clinical Lectures, 1848:* 27.
[150] For Conolly's distrust of medicine see Maudsley 1866; Scull et al. 1996: 48–82. For examples of other doctors sharing his approach see Hunter and Greenberg 1956.
[151] Maudsley 1866; Clark 1866: 58.
[152] Clark 1866: 58–61; Hunter and Macalpine 1968: 30.
[153] Clark 1866: 59.
[154] Hunter and Greenberg 1956. W. Gull was a famous physician and teacher. He lectured on natural philosophy, physiology and comparative anatomy at Guy's Hospital (1843–1856) and taught physiology at the Royal Institution (1847–1849). He treated the prince of Wales in 1871 and became a member of the GMC in the same year. *DNB*
[155] *Provincial Medical Journal and Retrospect of the Medical Sciences,* 4 (1842): 372–374.

year and each session lasted four months.[156] Moreover, for a few years in the 1850s Daniel Hack Tuke (1825–1895), son of Samuel Tuke and a trained physician, taught an annual course on insanity at the York Medical School which included clinical visits to the York Retreat. The contents of Tuke's lectures published in the *Asylum Journal* and some of his preparatory notes demonstrate that teaching at the York Medical School included a very detailed review of British and foreign literature and theory, discussed existing classifications and diagnostic criteria, and drew on the authority of those sources rather than on the teacher's own experience.[157] Unfortunately, the parts of the course on the treatment of mental diseases and details of clinical visits were omitted from the published lectures, and were only lightly touched upon in Tuke's notes.[158] It is clear even from the available texts that he supported the view that all medical practitioners would greatly benefit from learning psychological medicine and that in order to do so they had to receive clinical instruction at an asylum in addition to lectures and reading literature.[159] Finally, David Skae (1814–1873) started a course on insanity at the Royal Edinburgh Asylum in 1853, but we will take a closer look at it in the next chapter.

In the period between 1841 and 1858, none of the courses on mental disease in Britain were compulsory for students. Attending them was strictly voluntary and did not influence the students' opportunities in obtaining a medical degree or a license to practice. Nor were they necessary for securing a post at an asylum. The courses were few in number and depended heavily on the initiative of several alienists within an institution and their ability to organise and run classes. The overwhelming majority of medical schools and asylums were not particularly interested in establishing regular psychiatric teaching. Although the AMOAHI had been striving for establishing appropriate professional training on insanity from 1841, the absence of a central authority overseeing medical qualification or a single medical curriculum posed a significant obstacle to improving medical education, including instruction on insanity, and most changes remained local and short-lived. The efforts to overcome these major difficulties are the focus of the following section.

---

[156] Lewis 1967: 114; Crammer 1996: 212.
[157] Tuke 1856, 1857; [Tuke, Daniel Hack], 'Manuscript volume of parts of lectures on psychological medicine, to students at York Medical School by Daniel Hack Tuke', The Retreat Archive. REF/8/7/1. Hereafter: *Tuke's Lectures on Psychological Medicine*.
[158] Tuke 1857: 464.
[159] *Tuke's Lectures on Psychological Medicine*.

4. Standardising Medical Knowledge and Practices: 1858 Medical Act and the First Medico-Psychological Textbook

The two previous sections were dedicated to clinical teaching and its implementation in lunatic asylums. This section will focus on another important development of the period — standardisation of medical knowledge and practice. The chaotic and unregulated system of training resulted in wide variation in knowledge and skill between practitioners. Furthermore, a person's place within the medical hierarchy did not depend as much on their competence as on their social class, connections and corporate membership. Therefore, setting unified clear standards for medical training, certification and practice was an important part of the medical reformers' agenda. As most alienists belonged to the rank and file of the profession and were active in the PMSA and similar associations, they were heavily involved in campaigning for medical reform. Just as with clinical teaching, they also applied the general professional trend for standardisation to their own area of medicine. Whereas in the whole of the medical profession the standardisation came in the form of parliamentary legislation, in medical psychology it took the shape of the first British textbook on insanity. Below I will discuss the 1858 Medical Act and its functions and demonstrate that the first medico-psychological textbook aimed to solve many of the same problems but on a smaller scale.

The long and laborious legislative process leading to the Medical Act of 1858 started in 1840 with the "Bill for the Registration of Medical Practitioners, and for Establishing a College of Medicine and for enabling the Fellows of that College to practice Medicine in all and any of its branches and hold any medical appointment in any part of the United Kingdom," introduced to Parliament by Thomas Wakley, Henry Warburton and Benjamin Hawes.[160] It would take sixteen more bills, long deliberations and numerous amendments, before a document that could pass was formulated.[161] The main reason why it was so difficult was the complexity of the British medical profession at the time. As discussed in section one of this chapter, there was a sharp division between the general practitioners and elite hospital consultants. However, these two groups were also not homogenous. The elites were divided according to their corporate affiliation and geographic location; the general practitioners who belonged to different professional associations also often had different priorities. Although there had been an acknowledged need for medical reform since the beginning of the nineteenth century, these different factions saw the particularities of this reform differently.[162]

[160] Bills and Acts, Session 1840, 3: 17–50.
[161] Butler 1981: 62–64; Peterson 1978: 30–39; Roberts 2009; Waddington 1984: 77–95.
[162] Roberts 2009; Peterson 1978: 30–39; Waddington 1984: 53–95.

In the 1840s and 1850s the main force behind the reform and persistent search for an acceptable legislative solution were the general practitioners. The issues of medical education were at the heart of the changes proposed by them. Because professional training and licensing was integral to all discussion about the bills, in 1847 the Parliament ordered a new Select Committee on Medical Registration and Medical Law Amendment to closely examine the state of medical education in the country. After a two-year-long inquiry the Committee still could not produce clear recommendations, instead they published all of the evidence they had collected.[163] It was a powerful statement on the state of affairs in medical education: it was convoluted, chaotic and inconsistent. Nothing could have demonstrated the urgency of the reform more clearly. Most of the parties involved in the legislative process, although they disagreed on most issues, shared the view that education was the key to successful reform.[164]

General practitioners saw education as a solution to many of their problems. A standardised system of training and licensing of medical practitioners would help to overcome the medical hierarchy they saw as profoundly unjust. In their view members of the corporate elites achieved their position through nepotism and corruption rather than by being better qualified.[165] Designing a unified medical curriculum would entail defining the knowledge and skills which were important for a doctor thus making it easier for general practitioners to gain an equal standing with the elites by proving that they were just as competent. Unqualified practice remained an important issue for general practitioners, and they needed solid criteria to distinguish themselves from "quacks". This issue was not as straightforward as it might seem; even the government sometimes employed unqualified medical staff not understanding the difference.[166] Establishing standards for medical education would provide the foundation for qualitatively distinguishing licensed practitioners from the "quacks". In addition, general practitioners supported the unification of medicine into a single profession, as at the time only the doctors who practiced "pure" medicine or surgery were allowed to become fellows at the respective Royal Colleges which categorically excluded general practitioners from ever joining the corporate elite.[167] Scottish and Irish qualifications were not recognised by the London Colleges and in order to have a chance to advance their career the students of English provincial medical schools had to finish their education in London or abroad because medical training

[163] *First and Second Reports on Medical Registration and Medical Law Amendment, 1847–48; Third Report on Medical Registration and Medical Law Amendment, 1847–48.*
[164] Roberts 2009; Waddington 1984: 77–95.
[165] Butler 1981: 62–68; Peterson 1978: 16–30; Waddington 1984: 29–53.
[166] Loudon 1986: 208–14; Newman 1967.
[167] Peterson 1978: 6–12; Loudon 1986: 199–207.

outside of London was considered inferior by the licensing bodies.[168] Single standardised medical education would unite all medical professionals and eradicate regional differences.

Both the rank-and-file practitioners and the corporate elites were interested in demonstrating the scientific nature of medicine and their own status as learned professionals.[169] It would increase the prestige of the profession and further distance it from trade. A publicly known curriculum and criteria for medical licensing which could demonstrate the amount and the depth of scientific and clinical training would go a long way to strengthen the medical men's claim of scientific proficiency. Another reason for education featuring so prominently in the 1840s and 1850s medical legislation was the fact that all of the different factions had an interest in improving the quality of professional education as it would serve the advancement of medical science and bring public recognition to the profession as a whole. Lay legislators also saw better medical training as a public good.[170] Therefore, even though the different actors had different agendas and there was a struggle for power between them, medical education played an important role for all and provided a topic for productive negotiation.

Finally, after the eighteen years of intensive parliamentary deliberation the Medical Act of 1858 was passed.[171] It was significantly more moderate than the radical reformers had hoped and was met with less than universal satisfaction.[172] Nevertheless, it achieved some important goals. It provided a definition for a "qualified medical practitioner" and created the General Medical Council (GMC) responsible for registering all qualified practitioners in the country and publishing the list annually. The register was to include all the medical men regardless of their different qualifications and licences, but outside of its pages the corporate orders and hierarchies remained intact. The Act did not prohibit unqualified practice but forbade any state supported institutions, including lunatic asylums, to employ unregistered practitioners. However, other institutions, such as charitable hospitals or private madhouses, could hire whomever they wanted. The GMC was empowered to oversee medical education and certification, although the power to grant licences and set requirements for obtaining them remained with the corporations and universities. The representatives of all academic and non-academic licensing bodies had seats on the GMC and hence continued to exercise significant influence over the profession. The power of the GMC in the matters of education was only advisory. However, if it found the licensing requirements, curriculum or mode of examination

[168] Butler 1981: 41–46; Bonner 1995: 182–85.
[169] Peterson 1978: 30–39; Butler 1981: 62–68; Roberts 2009.
[170] Roberts 2009.
[171] Medical Act 1858, 21 & 22 Vict., c. 90.
[172] Peterson 1978: 35–39; Roberts 2009; Waddington 1984: 96–134.

inadequate the GMC could report it to the Medical Officer of the Privy Council and recommend stripping the offending body of the license-granting power.[173]

The direct effects of the Medical Act of 1858 on British alienists were not different to other rank-and-file practitioners. Even the ban on employing unqualified practitioners in the state-funded lunatic asylums did not introduce any changes because the Lunacy Commission had already recommended it. In terms of promoting instruction on mental disease, the Act showed some promise as it established a single body to oversee all medical education. The AMOHI and its members could negotiate with this single central authority instead of dozens of medical schools. However, in the first years of its existence the GMC had different priorities: it concentrated on investigating the existing education and examination at medical schools and universities, establishing the level of preliminary education required before commencing medical studies and designing the formal rules for medical education (for example, the length of the full course, minimum age of completion, timing and forms of examinations and so on).[174] The Council decided to consider the content of "purely professional education" and conditions for granting qualifications in medicine and surgery in later years.[175]

Nonetheless, the Act, and the prolonged legislative process, had significant *indirect* impact on medical psychology. Many of the alienists were members of other medical associations, most notably the PMSA, which took active part in bringing about the medical reform. A specially created Medical Reform Committee of the PMSA produced its own bill in 1854 and collaborated with the authors of a few later ones.[176] The details of the bills and parliamentary deliberations, and the report of the Select Committee on medical education were covered in detail in most medical journals. Hence, for many years British alienists had been daily reminded of the importance of professional education for medical practice and of standardising the core elements of professional knowledge for unifying the discipline and improving medicine's public image.

These issues were also relevant for medical psychology. The alienists' community had its own internal division between public and private asylum doctors which rendered the AMOAHI inefficient in representing the alienists' collective interests. There also remained the problem of treatment by unqualified practitioners and an even larger one of incompetence of

---

[173] Roberts 2009.
[174] *Minutes of the General Council of Medical Education & Registration of the United Kingdom; of the Executive Committee; and of the Brunch Counc*ils, 1858–1860, 1, Lothian Health Service Archive. GB239 GD5: 56–59; 72–77; 156–61. Hereafter: *GMC Minutes 1858–1860*.
[175] Ibid: 72.
[176] Newman 1967.

most doctors to properly diagnose insanity, even though legally all licensed medical men were empowered to certify the insane under the lunacy law.[177] Moreover, alienists often complained of the lack of professional and public recognition. An anonymous author claimed that some metropolitan physicians "consider it less degrading to keep a public-house than an asylum".[178] Daniel Hack Tuke in his lectures at the York Medical School observed that many medical men and lay people doubted the merits of studying medical psychology as they accused alienists of constantly disagreeing and contradicting themselves.[179] According to him this happened because most of the cases widely discussed outside of the alienists' community belonged to the category on the very edge of current knowledge. Pushing the boundaries of what was known inevitably entailed disagreement and further research. Tuke wrote that alienists as other "scientific men" would not be found "disputing and differing about the elementary facts of their science."[180] The problem was that "the elementary facts" had not yet been clearly articulated. Being aware of the advantages the standardisation and codification of knowledge offered to general medicine, in 1858 Daniel Hack Tuke and John Charles Bucknill co-authored the first textbook on mental disease in Britain – *A Manual of Psychological Medicine: Containing the History, Nosology, Description, Statistics, Diagnosis, Pathology and Treatment of Insanity.*[181]

As discussed in the previous chapter, there had already existed a significant body of literature on insanity. There had been medical treatises, periodicals, sections in books on other subjects, literature on asylum management and a host of phrenological publications. However, the *Manual* belonged to a relatively new genre of medical textbook. Its purpose was to systematically present the foundations of medical psychology to students and qualified practitioners who were not familiar with the subject. Unlike other types of literature on insanity, Bucknill and Tuke's textbook did not present new original research or its authors' particular views about insanity; instead, its pages contained the synthesised professional consensus on the foundations of medical psychology. The authors consciously avoided controversy and, where more than one accepted approach existed, they presented all of them, leaving it to the reader to choose. They also attempted to make the textbook comprehensive by covering all areas of medico-psychological knowledge. It included the chapters on:

---

[177] Ironically, only the practitioners connected to lunatic asylums were not allowed to certify lunatics to prevent corruption. Wright 1998.
[178] *Journal of Psychological Medicine and Mental Pathology*, 5 (1852): 160.
[179] *Tuke's Lectures on Psychological Medicine.*
[180] Ibid.
[181] Bucknill and Tuke 1858.

1. the history of insanity among the nations of antiquity;
2. opinions of ancient medical writers on the treatment of the insane;
3. the relationship between insanity and modern civilisation;
4. improvement of the conditions of the insane in modern times and abandonment of mechanical restraint;
5. definitions and classifications of insanity;
6. forms of mental disease;
7. statistics of Insanity;
8. diagnosis of insanity;
9. pathology of insanity;
10. treatment of insanity;

and a collection of cases to illustrate pathology and treatment of mental disease.

The *Manual* was written in a neutral tone with evident effort to make the text clear and easy to navigate. Bucknill and Tuke divided their labour according to their strengths and experience with Tuke working on the more theoretical chapters of the first half of the book and Bucknill contributing the practical and clinical chapters on diagnosis, pathology and treatment. The authors referred to many other works, but the textbook did not assume any special knowledge on insanity from its reader. The *Manual's* structure was also characteristic of a textbook: the chapters progressed from general to particular and from theoretical to practical. In the words of the authors, they aimed to make the textbook "sufficiently elementary" to be used by students and "sufficiently modern in its views, and explicit in its teachings, to suffice the demand of the practitioner."[182]

Bucknill and Tuke correctly identified the need of the medical community and successfully addressed them in the *Manual*. Thus, it was quickly embraced and endorsed by the profession. It was widely and positively reviewed, went through four editions (published in 1858, 1862, 1874 and 1879) and remained the standard textbook on mental disease for over a quarter of a century.[183]

It was not a coincidence that the *Manual* was published in 1858. Apart from the zeitgeist of British medicine in the 1840s and 1850s, there had been many important developments

[182] Bucknill and Tuke 1858: ix–x.
[183] For a detailed history and analysis of the *Manual* see Merkulova 2016. For examples of reviews see: *The Journal of Psychological Medicine and Mental Pathology*, 9 (1858): 635–40; *London Medical Review*, 2 (1862): 577–87; *Lancet,* 71 (1858): 505–06; *Americal Journal of the Medical Sciences,* 72 (1858): 459–68; *Law Magazine and Law Review*, 5 (1858): 321–32; *Westminster Review,* 70 (1858): 258–59; *Examiner*, 1 May 1858, p. 4; *Athenaeum*, 5 February 1859, p. 192.

within medical psychology itself that led to the possibility of creating such a textbook. First of all, the foundation and growth of the AMOAHI fostered alienists' collective professional consciousness. It helped to define the boundaries of medical psychology within medicine and draw a clear distinction between medical and lay approaches to insanity. The Association's annual meetings and the *Asylum Journal* provided the platform for exchanging knowledge and holding professional discussions. The lunacy legislation of 1845 defined the legal aspects of medico-psychological practice. It put all counties under the obligation of building rate-supported pauper lunatic asylums which offered more jobs for medical practitioners within the lunacy system and added to the growth of the professional community. As discussed in the first section of this chapter the Lunacy Commissioners' annual reports helped to define and clarify the standards of good asylum practice. Finally, the organisation of the clinical courses on insanity called for systematising and organising knowledge on the theory and treatment of mental diseases for pedagogical purposes. It is important to notice that the authors of the *Manual* were personally connected with all of these changes. Bucknill was an active member of the AMOAHI, the editor and a frequent contributor of the *Asylum Journal* and, therefore, he was very well informed of all of the latest debates and developments in medical psychology and used to presenting them in writing for a wide readership.[184] His co-author, Tuke came from the dynasty of lunacy reformers and had a first-hand experience of running a course on insanity for medical students.[185] His family name, awareness of the students' needs and eagerness to improve the fate of asylum patients contributed to the textbooks success. Moreover, it was important that one of the authors, Bucknill, was the superintendent of a large public asylum and the other, Tuke, had experience working at the celebrated subscription asylum — the York Retreat.

The most important function of Bucknill and Tuke's *Manual* was that it created British "textbook medical psychology". According to the continuity model of science communication this is a crucial stage of the circulation of scientific knowledge from the communities of specialist to the general public.[186] Communications between specialists are nuanced and often uncertain or controversial, so if a lay person becomes privy to them, they do not understand much and might get an impression that there is no agreement between the specialists at all. However, when the aim is to communicate scientific or medical information to a student, it is necessary to reduce its complexity and increase certainty. The teacher's goal is to provide the

[184] Scull et al. 1996: 187–225.
[185] *DNB*.
[186] Cloître and Shinn, 1985; Bucchi, 2008.

students with an accessible and reliable foundational knowledge. This is why the "textbook knowledge" is so important, as this is the level at which the "facts" of the discipline are created.[187] Tuke himself explained just as much to his students in 1850s when he said that the debates between alienists were too complex and concerned the very advanced areas of medical psychology, which were simply inaccessible to a less informed person.[188] The *Manual* bridged the gap in communication between highly specialist and popular knowledge and did not merely present, but actively created professional consensus and medico-psychological facts.

In accordance with its authors wishes, the *Manual* provided much needed cohesion to the alienists' community, made medical knowledge about insanity available to all who needed it and offered powerful testimony for the necessity of special professional knowledge for diagnosing and treating mental disease. It reassured the lay readers of the alienists' expertise and helped to improve psychiatry's public image. Finally, the clear articulation of the core elements of psychiatric theory and practice for pedagogical purposes had been a necessary step before the alienists started petitioning the GMC for inclusion of psychiatric instruction into the compulsory medical curriculum in later periods. After all, the alienists first had to know what exactly they would like to be known by all medical students so they could pitch it to the GMC and the licensing bodies. However, this is a story for the following chapters.

Conclusion

In the 1840s and 1850s British alienists were deeply involved in two major reform movements: for changing medicine and for improving lunatic asylums. Both of these had important consequences for medical psychology. As a branch of medicine, medical psychology had to comply with the current medical standards, theories and legislation. As part of the lunacy system, asylum practitioners were governed by an additional set of laws and overseen by a special Lunacy Commission. Sometimes this two-fold identity of medical psychology led to complications and problems, unique to this area of medical practice, but in general the main trends in professional politics, education and research were the same in medical psychology as in the rest of medicine.

As other general practitioners, British alienists were discontented with their low place in the medical hierarchy and felt that their concerns were either unheard or ignored by the corporate elites. Inspired by the example of medical associations founded to represent general

[187] Fleck 1979.
[188] *Tuke's Lectures on Psychological Medicine.*

practitioners as a whole or groups of them based on locality or occupation alienists founded their own organisation in 1841 — the Association for Medical Officers of Asylums and Hospitals for the Insane. It promoted the image of medical psychology as deeply rooted in medical theory and requiring a great deal of special knowledge and skill. The AMOAHI's annual meetings and the *Asylum Journal,* founded in 1853*,* provided British alienists with a platform to share knowledge and establish the main principles and standards of medical care for the insane. One of the key characteristics of asylum practice from the mid-1840s was the abolition of mechanical restraint, which became viewed as both unnecessary and harmful. The proponents of the non-restraint system claimed that alienists' medical knowledge and clinical judgement provided them with better means of guaranteeing their patients' safety and manageability within the walls of the asylum. The use of restraint became a sign of incompetence and served to distinguish between the humane and enlightened medical treatment of insanity and the cruel and ignorant lay practices of earlier times.

If asylum practice required special medical knowledge and skills, there was a need for special medical training on insanity. In general medicine and surgery in the 1840s and 1850s clinical instruction was in vogue and formed an important part of medical education and certification. An apprenticeship supplemented with odd lecture courses was widely recognised as an out-dated and ineffective way of teaching medicine and it was inadequate for training students in the new clinical methods. Thus, it was supplanted by clinical instruction at teaching hospitals. Here, again, alienists shared the views of the medical profession as a whole and worked to establish modern training in their own area. However, there were particular challenges to organising clinical instruction on mental disease. Insane patients were not admitted to most of the teaching hospitals, hence organising a course there was not possible. Moreover, the asylum itself was considered an important part of treatment and the skill of managing an institution was key to a successful medico-psychological career at the time, therefore the asylum was the best site for teaching. This posed further problems, as the lunatic asylums were often remotely located and understaffed. Some lay governors who oversaw the institutions were reluctant to allow clinical courses out of concern for the patients' wellbeing. These obstacles, although not insurmountable, made arranging clinical instruction on mental disease very difficult. The few courses that did take place relied heavily on the initiative and connections of the medical officers who organised them.

One such course was run by John Conolly at the county asylum in Hanwell. It took place annually from 1842 until 1849. The groups of 10-15 medical students from metropolitan schools visited the asylum once a week. Each visit consisted of "walking the wards" under the

direction of a medical officer and a lecture on insanity, asylum practice and treatments, which built on the cases observed in the wards. One of the main attractions of the course was that it offered detailed practical instruction on managing a large asylum without using mechanical restraints.

Although the pedagogical techniques in medical education changed compared to earlier decades of the century, the system of education remained disorganised and varied in quality. Hence, improving and standardising medical training and licensing constituted an important part of the mid-century campaigns for medical reforms. The numerous legislative attempts and laborious deliberations led to the passing of the Medical Act in 1858. The Act provided the framework for standardisation of medical training and established the General Medical Council to oversee it but it did not directly affect medical psychology as much as it did other areas of medicine, as many of its clauses had already been recommended by the Lunacy Commission. Yet, the process of developing that piece of legislation and the debates it sparkled in the medical circles demonstrated the importance of standardising training and articulating the core elements of a discipline. The alienists' attempts to do the same with their area of medicine took the form of the first textbook on insanity. *A Manual of Psychological Medicine* came out the same year as the Medical Act and it served to define systematised, comprehensive and consensual medical knowledge on mental diseases.

Chapter 3. Scientific Training: Defining and Teaching Science-Based Medical Psychology, 1859–1875

Introduction

In the presidential address to the MPA in 1869, Thomas Laycock claimed that the "combination of science and practice in teaching has been my object for the last twelve years in my courses on Medical Psychology and Mental Diseases, with results fairly satisfactory."[1] In the previous chapter, we have seen that clinical training (or "practice" in Laycock's terms) was at the forefront of educational developments in medical psychology from 1841 to 1858. Courses on mental diseases took place at lunatic asylums where medical students walked the wards accompanied by the asylums' medical officers and learned the practical aspects of diagnosing, treating and managing mental patients. In the following two decades the approach to teaching on insanity changed to prioritise scientific instruction. This chapter will explain the reasons for this change and demonstrate how the courses on mental diseases were transformed to accommodate the demands of the new pedagogy between 1859 and 1875.

The growing importance of science was not restricted solely to the domain of medical psychology but penetrated many areas of mid-Victorian life: from new ways of farming and housekeeping to heavy industry; from children's books to religious sermons. By the middle of the nineteenth century, confidence in the power of science to solve pressing social, economic and political problems was widely shared.[2] The second half of the century saw the establishment of a new ideal of science as institutionalised and conducted in laboratories by specially trained men.[3] Universities and other educational institutions started to play a double role as training sites for the new professional scientists and as their potential employers. The whole idea of what should constitute university education was changing at the time and scientific training was assuming a prominent position with the University of London offering some scientific training since 1828, Cambridge and Oxford undergoing a reform in 1850–51 to establish scientific degrees, and the founding of civic colleges in Manchester, Sheffield and Leeds which provided instruction on scientific and technical subjects.[4] By the mid-century, Scottish universities, especially in Edinburgh and Glasgow, also commonly offered courses on

[1] Laycock 1869: 340.
[2] See for example, Lightman 1997; Russell 1983.
[3] Quick 2014: 64.
[4] Anderson 1992; Brock 1990; Butler 1986, 1988; Engel 1983; Argles 1964; Kraft and Alberti 2003; Gooday 1991a.

scientific disciplines.[5]

One of the areas most affected by this scientific turn was medicine. Since the debates preceding the 1858 Medical Act, British medical practitioners had sought to increase the prestige and popularity of their profession through an association with science.[6] Many of them shared the contemporary confidence in the power of science to create positive change, including bringing about advancements in medical treatment and disease prevention.[7] Many of the British doctors who trained in the first half of the nineteenth century completed their MD degrees abroad — in Germany and France. They drew the attention of their colleagues, legislators and the general public to the impressive medical advancements which were being achieved on the Continent and connected them with the model of training which combined scientific and clinical instruction.[8]

The General Medical Council, created in 1858 and tasked, among other things, with ensuring a high standard of medical education, introduced compulsory laboratory courses into the medical curriculum, which had a significant effect on the development of British higher education and career structure in the sciences. The rigorous scientific training recommended by the GMC demanded costly laboratories and qualified full-time teachers. Many of the provincial medical schools could not afford the expense and had to close, whilst other allied themselves with local civic colleges as did the medical schools in Manchester, Leeds, Sheffield and Liverpool.[9] This was an important step towards the foundation of civic universities in these cities. The new medical education requirements created salaried full-time positions for scientists who taught laboratory subjects to medical students and often carried out their own original research. This provided the infrastructure for a new position within the medical hierarchy (besides hospital consultants and general practitioners) — the medical scientist.[10]

As with the rest of the medical profession, practitioners involved in the treatment of insanity saw advantages in associating their domain with science. They too sought to gain respect for their branch of medicine and to strengthen their claim to special expertise. Arguably, these problems were more pressing in medical psychology than in general medicine at the time. Between 1858 and 1878 the growing fear of wrongful confinement and a series of lawsuits against alienists significantly damaged their public image.[11] At the same time the asylums were

[5] Brock 1990; Argles 1964; Gooday 1991a.
[6] Roberts 2009; Butler 1988.
[7] Bynum 1994: 118–42, 218–26.
[8] Bonner 1995: 231–50; Bynum 1994: 92–118.
[9] Butler 1986, 1988; Bonner 1995: 251–71; Bynum 1994: 176–216; Gooday 1991a.
[10] Bynum 1994: 92–118, 218–26.
[11] McCandless 1981.

accumulating larger numbers of patients but could not offer any effective cures. This led to the spread of therapeutic pessimism amongst asylum officers and to depictions of asylums as places of imprisonment rather than medical treatment.[12] Many British alienists argued that scientific research of mental diseases and improvements in medical training would lead to advancements in diagnosis, treatment and prevention of insanity, hence alleviating the problems stated above.

However, what constituted scientific medical psychology was highly contested. Most British asylum superintendents constructed their own frameworks for understanding mental diseases which significantly contradicted one another. Most of these frameworks had only two assertions in common. First, that the brain was the organ of the mind and that scientific medical psychology had to be based on physiology and pathology of the brain. Second, that heredity played an important role in the development of mental disease. By the end of the 1870s both of these claims were widely accepted.[13] However, even these general assertions were often interpreted and applied differently by different medical practitioners. If in academic and professional discussions alienists were surprisingly accepting of the plurality of approaches it was harder to reconcile in an educational environment where the goal was to create an effective standard curriculum.

At the same time the professional identity of British medical practitioners engaged in treatment of the insane was also changing. If in the period between 1841 and 1858 they defined themselves primarily through their place of employment, the asylum, then in the following years they emphasised their shared area of special scientific and practical interest — medical psychology. This shift was embodied in the change of the title of the AMOAHI to the Medico-Psychological Association (MPA) in 1865. At the same time the rules of the Association were revised to accept as members not only practitioners employed at asylums, but all medically qualified men interested in insanity.[14]

In the first half of this chapter, I will examine the key aspects of the development of scientific medical curriculum and the emergence of scientific medical psychology in Britain in the period between 1859 and 1875. In Section 1, I will focus on the educational recommendations of the GMC and demonstrate that the goal of introducing more scientific and laboratory courses into the curriculum was not only to train medical students in conducting

[12] Scull 1993: 267–333; Finn 2012: 110–20; Melling and Forsythe 2006: 46–47.
[13] Oppenheim 1991: 16–53; Danziger 1982; R. Smith 2013; Quick 2014.
[14] *JMS*, 11 (1865): 383–427; Renvoize 1991; Bewley 2008: 23–40.

research but also to develop the skills of reasoning and observation. I will also elucidate how British alienists attempted to redefine their area of medicine as scientifically based and to restructure their professional community to accommodate this new self-image.

In Sections 2 and 3, I will discuss how the changes in medicine as a whole and medical psychology in particular impacted education on mental diseases. I will focus on two conflicting pedagogical approaches employed in Edinburgh at the same time by Thomas Laycock and David Skae. In Section 2, I will explore both teachers' interpretations of what constituted scientific medical psychology and explain how and why it led to a public dispute. In Section 3, I will demonstrate that the conflict between Laycock and Skae was mostly pedagogical. It was concerned with the right way of teaching scientific medical psychology rather than with the right way of practicing it. These educational considerations had important implications for the shaping of medical psychology as a branch of medicine.

Finally, in Section 4, I will show that towards the end of the period emerged a new model of teaching scientific medical psychology pioneered by James Crichton-Browne in the West Riding Lunatic Asylum. It combined aspects of both Skae's and Laycock's approaches and aimed to answer the most pressing problems faced by British medico-psychological community. I will demonstrate that, for Crichton-Browne, scientific medical psychology was largely a laboratory-based enterprise and, therefore, he equipped his asylum with two laboratories — pathological and histological. His pedagogical approach was characterised by distinguishing between two types of learners: undergraduate medical students, who needed an introductory course, and recently qualified medical practitioners, who wanted to advance their knowledge of mental disease. Both types of learners engaged with clinical and theoretical aspects of treating, diagnosing and researching insanity. However, whereas undergraduate medical students mainly received theoretical information and became aquatinted with the basics of clinical work at the asylum, the training received by the young practitioners involved honing their scientific skills by conducting their own research and acting as clinical assistants to the asylum's staff. This two-tier model of training in scientific medical psychology required a close collaboration between a medical school, the asylum wards and laboratories.

1. Scientific Medicine and Alienists as Scientific Practitioners

Between 1859 and 1875 one of the most significant features of general medical education and teaching of psychological medicine was the growing emphasis on science. The necessity of scientific knowledge for medical research and practice was an important part of the medical reform rhetoric both before the 1858 Medical Act and in later attempts to amend it.[15] The idea of close connection between science and medicine was employed to reinforce the authority of medical men and improve their social standing.[16] For example, it served to elevate licensed medical practitioners over unlicensed competitors. The former argued that their scientific education enabled them to reliably identify, treat and prevent diseases whereas the unlicensed "quacks" lacked the necessary scientific knowledge and, hence, their medical opinions were unreliable.[17] The expectations that scientific research would advance clinical medicine were supported by such indisputable successes as the introduction of chemical anaesthesia in 1840s and Lister's antisepsis in 1860s.[18] Therefore the scientific foundations of medical practice and the space they should occupy in training new practitioners became a popular topic of public and professional debates.[19] In this section I will discuss the changes in education which made science an integral part of medicine and the attempts of alienists to make their area of medicine more scientific.

In 1859 the GMC established a special committee on education and started taking an increasingly active part in shaping British medical training. Historian Stella Butler argued that the formation of the GMC provided a platform for the medical licensing bodies to agree on the basic curriculum and ensured that it was implemented.[20] The Council's recommendations did not cause much resentment, as it was perceived as an intra-professional body.[21] The membership included the representatives of all licensing authorities and even the Crown appointed members were medical professionals. Therefore, all of the GMC's directions and suggestions were mostly based on collective decisions and relied on the support of the licensing bodies, striking a compromise between centralised governance of the profession and the autonomy of individual members.

In the early 1860s the GMC started introducing changes to medical education. First, it

[15] Roberts 2009; Butler 1981: 62–118
[16] Bynum 1994: 118; Butler 1988.
[17] Newman 1957: 194–261; Danziger 1982: 121; Roberts 2009.
[18] Roberts 2009: 54; Bynum 1994: 118–42.
[19] Bonner 1995: 259–64; Butler 1981: 62–118; 1988.
[20] Butler 1981: 62–118.
[21] Roberts 2009; Waddington 1984: 176–205.

recommended that not only qualified practitioners, but also medical students should register with the Council. In order to register they had to demonstrate that they had successfully passed required examination in general knowledge. Only then they would be allowed to commence their professional studies.[22] The purpose of this preliminary examination was to ensure that all the medical students had the same level of education at the beginning of their studies and could follow the same curriculum. This was a significant innovation compared to the first half of the century when the students of different social classes started out with vastly different educational foundations.[23] According to the new rules, the specifically medical stage of education had to take no less than three years and to include two sets of examinations: first at the end of second year and second at the end of the whole course.[24] In the late 1860s the GMC compiled the first basic necessary curriculum and divided it into preparatory and medical subjects.[25] The former were to be learned by the students in the first two years and examined during the first set of examinations. Having passed those medical students could move on to specifically medical and clinical subjects and prove their acquired knowledge and skill during the second set of examinations.

From the outset the Committee on Education of the GMC emphasised the need for the improvement of medical practitioners' scientific training. In 1864 the Committee declared that it encouraged teaching of science to medical students.[26] In 1869 the GMC published a new report which stressed the importance of practical laboratory learning.[27] The new recommended curriculum included compulsory laboratory training in chemistry and instruction in microscopy as part of physiology course. In the 1870s the minimum length of study for medical students was extended from three to four years to accommodate the new demands of science, and the new requirements included laboratory courses in chemistry, physics, physiology and pathology.[28] The arguments for strengthening the scientific training of medical students did not consist only of the possible direct applicability of scientific knowledge to medical practice but also maintained that learning sciences would sharpen the minds of future doctors and help them develop important skills such as keen observation and clear reasoning.[29] By the 1870s talking of medicine as a science became commonplace amongst practitioners and medical students

[22] "Minutes of the General Medical Council", LHSA, GB239 GD5, 1860, pp. 85–87, 99–102, 123–26, 156–61. Hereafter: *GMC Minutes.*
[23] Bonner 1995: 72–80; Rosner 1991.
[24] *GMC Minutes,* 1860: 156–161.
[25] *GMC Minutes,* 1869: 93.
[26] Butler 1981: 65, 1986: 119.
[27] *GMC Minutes* 1869: 78–95.
[28] Bonner 1995: 259; Bynum 1994: 218–26; Gooday 1991a; Butler 1988.
[29] Butler 1981: 66.

unreservedly called themselves “men of science” and engaged in original research during their studies.[30]

As a part of the medical community, alienists also welcomed the strengthening of ties between medicine and science and anticipated the professional advantages it would bring. However, the task of demonstrating that medical psychology was just as scientific as the rest of medicine posed difficult problems. In the 1840s and 1850s British alienists forged a collective professional identity for themselves but it did not rely on a shared understanding of mental disease, instead the alienists were united by the type of institution they worked in — the lunatic asylum.[31] This allowed them to enjoy the advantages of a cohesive community which nevertheless could tolerate a high degree of heterogeneity in theories and practices. In the 1860s, when the medico-psychologists had to present evidence of the scientific character of their branch of medicine, they encountered an unforeseen complication: although most of them agreed that scientific training and research were important, there was no consensus on what it meant to be scientific about the mind and its disorders. It did not help matters that understanding the mind, its function and nature was a popular topic amongst the wider British public which brought additional attention to the debated within medical psychology.[32] Defining the science of medical psychology was further complicated by the changing meaning of science in the general discourse, as it was only by the end of the nineteenth century that the modern definition of the word became standard.[33] Furthermore, alienists had to devise scientific ways of researching and explaining mental diseases which were not immediately observable in the same way as bodily ailments. There existed no stethoscope for examining the state of a person’s mind. Hence, there was a lot of room for different conceptualisations of both science and mental disorders which led to a diversity of approaches.

Nevertheless, there were two commonly accepted principles. The first one was “the axiom that the Brain and the Nervous System are the organs on which the Phenomena of Mind depend,” which suggested that medical psychology’s scientific foundation was to be found in physiology and pathology of the nervous system.[34] This was in keeping with the rest of medicine as it was also increasingly looking to physiology for scientific explanations.[35] Other popular sources of scientific support for medical psychology were comparative anatomy and

[30] Bonner 1995: 252.
[31] Renvoize 1991.
[32] R. Smith 2013: 39–67; Adriaens and Brock 2010.
[33] Bowler and Morus 2005: 319–39.
[34] Sankey 1866: 1; R. Smith 2013: 39–51; Jacyna 1982; Chaney 2013: 42–47.
[35] Butler 1981: 208–64, 1988.

physiology. These were well-established research disciplines which lent additional legitimacy to the alienists' theories.[36]

The second consensual medico-psychological principle was that mental health and illness were at least partly hereditary. Darwin's *The Origin of Species* published in 1859 reinvigorated the mid-century transmutation debates and introduced a new evolutionary thinking to medical researchers. Although Darwin's theory was far from universally accepted, it was a highly publicised and polarising issue and most practitioners took a side in the controversy.[37] Since heredity played an important role in explaining mental disease, evolutionary theories offered an attractive scientific foundation for these explanations. Therefore, many alienists incorporated elements of different evolutionary approaches in their theories.[38]

One of the predominant approaches in medical psychology based on both of these shared principles was the degeneration theory of insanity developed by an English alienist Henry Maudsley (1835–1918), whose work loomed large in medico-psychological thinking during the 1860s and 1870s.[39] He claimed that all mental diseases arose from the pathology of the brain and the nervous system, hence to understand the functioning of the mind and specific causes of mental disorders one had to study physiology and pathology, not psychology or metaphysics.[40] According to Maudsley, the pathological changes of insanity were the manifestation of degeneration — the regression to earlier evolutionary forms.[41] He argued that this was the reason why the behaviour of the lunatics looked bestial. Maudsley attributed the cause of degeneration to immorality and vice, the morbid habits such as drunkenness or promiscuity which could be inherited by future generations and create physical changes in the nervous system.[42]

At first glance, Maudsley's theories and their connection to the avant-garde of mid-Victorian scientific thinking was affording medical psychology further legitimacy and prestige. However, the degeneration theory ultimately brought into question the usefulness of medical psychology as a whole: it suggested that insanity could not be cured and reinforced alienists' therapeutic pessimism.[43] It called asylum doctors to cease their futile attempts at treatment and

[36] Quick 2014.
[37] R. Smith 2013: 51–62; Desmond 1989.
[38] R. Smith 2013: pp. 51–62; Oppenheim 1991: 182–87, 269–92; Adriaens and Brock 2010.
[39] R. Smith 2013: 44; Oppenheim 1991: 265–92; Scull 1993: 324–31; Rollin 1991.
[40] Maudsley 1870; Scull et al. 1996: 235–37.
[41] Maudsley 1870; Oppenheim 1991: 269–92; Scull et al. 1996: 239–42; Finn 2012: 116–19.
[42] Maudsley 1867, 1870; Scull et al. 1996: 234–37; Scull 1993: 324–332; Oppenheim 1991: 265–92.
[43] Oppenheim 1991: 265–92; Scull 1993: 324–32; Finn 2012: 116–19.

to instead concentrate on isolating the insane from the rest of society and taking care of them until they die.[44] This unflattering and pessimistic view about the role of medical psychology accounted for Maudsley's relatively brief period of popularity.[45] It also showed that, even though it was important for medical psychology to demonstrate that it was based on science, ultimately, the science was needed to support the professional interests of the asylum doctors. If a science undermined them, it was soon rejected by the professional community.

In the 1860s the structure of the alienists' community was also changing. As already mentioned, in the earlier period, employment at an asylum served as the foundation for the medico-psychologists' collective identity. In the mid-1860s this foundation ceased to be sufficient. The alienists wished to demonstrate that they were not just a group of employees, like Poor Law Medical Officers or army doctors, but represented a distinct branch of the medical profession with its own special area of expertise.

This was particularly important because, by the middle of the nineteenth century, asylum doctors' image sustained significant damage from the claims that sane people were wrongfully confined in mental institutions for sinister reasons or because of incompetent diagnosis.[46] Popular novels such as Charles Reade's *Hard Cash* (1862) and Willkie Collins' *The Woman in White* (1859) vividly portrayed how easily a sane person could be committed to an asylum and how difficult it was to get out. The fear of wrongful confinement was so strong and prevalent that two parliamentary select committees were appointed during the period: in 1858-1859 and in 1876-1877.[47] Nonetheless, no amount of reassurance from the authorities managed to allay the public's suspicions. The horrible abuses publicised by the lunacy reformers in the first half of the century were still fresh in the minds of British people and the rapid growth of asylums added to the popular misgivings.[48] Hence, it was integral to the professional wellbeing of medico-psychologists to improve public opinion about them and offer an alternative image of highly competent, knowledgeable and scientific medical practitioners.

The shift from the collective identity of alienists as asylum officers to experts in medical psychology was especially noticeable in the transformations of their professional association. The rules of the AMOAHI, established at its foundation in 1841, stated that only medical

[44] Scull 1993: 324–32; Scull et al. 1996: 239–42; Finn 2012: 116–19.
[45] Scull et al. 1996: 242–50.
[46] McCandless 1981; Brückner 202; Wright 1998; Schwieso 1996; Owen 1989: 139–201.
[47] McCandless 1981; Scull 1993: 307–08; Owen 1989: 139–201.
[48] McCandless 1981: 340.

practitioners employed in public or private asylums could join as regular members.[49] There were a few exceptions; some were accepted as honorary members in recognition of their important contribution to the study and treatment of insanity (for example, Samuel Tuke, an important figure in the lunacy reform movement) but in the overwhelming majority of cases the rule was upheld. After a lively discussion at the annual meeting in 1865 the rules were amended. The new membership eligibility clause read:

> [t]he Association consists of medical officers of hospitals and asylums for the insane, public and private, and *legally qualified medical practitioners interested in the treatment of insanity*.[50]

After this amendment, the majority of the Association's members still consisted of asylum officers but there appeared a significant number of members engaged in regular private or hospital practice or scientific medical research.[51] The title of the association also changed to reflect the new identity of the members: it became the Medico-Psychological Association (MPA).[52] The association's journal had already lost the word "asylum" from its title and had been published as the *Journal of Mental Science* since 1859. In the 1860s and 1870s, the periodical's content was gradually changing to include more abstract and scientific papers on different aspects of medical psychology and less practical advice on the day-to-day running of an asylum.[53]

The distribution of power within the MPA also reflected the changes in alienists' professional identity and values. For example, in 1853 the editorship of the Association's journal was entrusted to John Charles Bucknill — a seasoned 36-year-old practitioner with almost a decade of experience as an asylum superintendent and an impeccable track record with the lunacy commissioners. Furthermore, the presidents of the AMOAHI were elected on the grounds of long and faithful service to the profession and their experience of treatment and management of the insane. However, when Bucknill stepped down from his post as the editor, he was replaced by two co-editors: Charles Alexander Lockhart Robertson (1825-1897), also an experienced asylum superintendent, and Henry Maudsley, who, at the time, was 24 years old and had only briefly worked in an asylum. His candidature for editorship was justified simply: "Dr. Maudsley — a name that […] every gentleman who reads the Journal will

---

[49] *MPA Minutes, 1841–1855*. 29 September 1941.
[50] *JMS*, 11 (1865): 396. Emphasis mine.
[51] Renvoize 1991: 41–42.
[52] *JMS*, 11 (1865): 396.
[53] Scull et al. 1996: 233–234, 237–238.

appreciate" referring to the several papers he had already authored.[54] In 1870 at the age of just 35 he became the senior co-editor of the *Journal of Mental Science* and was elected president of the MPA, with his colleagues claiming that

> we do ourselves honour by electing Dr. Maudsley to a much greater extent than we honour him. He is a man whose reputation is European; he is a man who has done more than any living psychologists in this country for our science.[55]

Maudsley's achievement which led to this gushing praise was the publication of his scientific theory of mental disease, discussed earlier in this section. Thus, the new position of power and regard within the professional community was bestowed upon him for his perceived scientific brilliance.[56] This further indicated that the alienists' community preferred to be represented by a well-known researcher on medical psychology rather than an experienced asylum superintendent. Although Maudsley's influence was ultimately short-lived, it illustrated the general direction of the changes in the social structure of British medical psychology.

The distancing of the professional identity from the asylums also reflected the alienists' growing desire to develop their career beyond the walls of special lunatic institutions.[57] Even though the 1858 Medical Act brought a little more order into the profession and the GMC worked at standardising the curriculum, there remained a deep division between the rank-and-file and the elites of the profession. The elites still comprised the ruling authorities of the Royal Colleges in London and Edinburgh and hospital consultants, especially those who taught students.[58] The majority of lunatic asylums were far from the centres of medical power and the appointments there did not provide the same professional visibility and respect as the hospital posts. Therefore, the alienists had to carve new career avenues for themselves: as private practitioners, lecturers at medical schools and scientific gentlemen. Here, again, Henry Maudsley furnished us with a good example. He quickly abandoned his post at an asylum in Manchester and moved back to London in 1862. He wrote prolifically and ingratiated himself with the most important members of the MPA, obtained a Junior Physician's post at the West London Hospital in Hammersmith in 1864, published his first book *The Physiology and*

[54] *JMS*, 8 (1862): 457.
[55] *JMS*, 16 (1870): 455.
[56] Scull et. al. 1996: 238.
[57] Oppenheim 1991: 25–26.
[58] Hardy 2001: 2–29; Bonner 1995: 259–264.

Pathology of Mind in 1867 and became a Fellow of the Royal College of Physicians in 1869.[59] Other practitioners also pursued careers outside of the asylum: W.H.O. Sankey (1814–1889), a medical officer at Hanwell, resigned in 1864 and became a lecturer on mental disease at the UCL.[60] J. C. Bucknill left his post as an asylum superintendent in 1862 to become the chancery visitor in lunacy and from 1876 practiced as a private consultant in London.[61] He became an influential figure at the Royal College of Physicians in the 1870s and, according to the time, built himself an illustrious medical career.

The changes in the structure of the alienists' community and the transformation of their professional identity did not only bring new opportunities but also caused significant difficulties. The new foundation for the collective identity — a shared interest in insanity — did not automatically lead to a shared approach to research, nosology and therapeutic practices. These divisions were added to the already existing rift between the officers of private and public asylums, and now a number of the MPA members had no interest in the asylums at all and even questioned their usefulness. This resulted in the weakening of cohesion in the medico-psychological community and highlighted the heterogeneity of the members' views. Although the MPA attempted to present a united front of scientific medical psychologists, it was writhing with internal divisions and disagreements.

2. Defining Scientific Medical Psychology: David Skae and Thomas Laycock

Nowhere was achieving at least a semblance of consensus as crucial as in the area of education on mental diseases. British alienists strove to introduce scientific training into medico-psychological courses, although, just like in general medicine, it did not replace clinical instruction. On the contrary, some asylums still offered primarily clinical courses well into the 1870s. Yet other medical schools and asylums developed new courses which emphasised scientific aspects of medical psychology and promoted research in addition to clinical instruction in the asylum wards. It helped that by the 1860s many of the difficulties previously associated with teaching at lunatic asylums had been resolved. Many of the asylums became easily reachable by train and the experience of student groups attending the wards in the 1840s and the 1850s proved that their visits did not harm the patients. Unfortunately, with the clinical component more or less settled, the teachers of medical psychology encountered a

[59] Scull et al. 1996: 231–33; Oppenheim 1991: 25; Rollin 1991.
[60] Scull et al. 1996: 234; *BMJ*, 1 (1889): 689–90.
[61] Renvoize 1991: 45–46; Scull et al. 1996: 215–223; Beveridge 1998.

new set of problems, this time related to the scientific component of training. Lack of consensus on what constituted the science of medical psychology meant that there were many competing theories of mental diseases, methodologies of research and rationales for treatments. Furthermore, different instructors had different ideas about the goals, content and methods of teaching medical psychology to students. This plurality of approaches was a significant obstacle to developing a standard course of instruction on mental diseases or unified criteria for the knowledge and skills that were desired of the graduates of such a course.

In this section I will closely examine two courses on mental diseases conducted in the 1860s and early 1870s — one taught by Thomas Laycock (1812–1876) at the University of Edinburgh, the other — by David Skae (1814–1873) at the Royal Edinburgh Asylum. These courses illuminate key scientific and pedagogical issues of teaching medical students about mental illness in mid-Victorian Britain. Conducted in the same city at the same time by instructors who were almost perfect contemporaries, the Edinburgh courses provide a unique opportunity for comparison. Moreover, they deserve special attention because of their significant impact on British alienists. Many of Laycock's and Skae's students went on to become important figures for medical psychology and neurology, for example James Crichton Browne (1840–1938), Thomas Clouston (1840–1915), David Ferrier (1843–1928), David Yellowlees (1837–1921) and John Batty Tuke (1835–1913), all of whom admitted the importance of their instruction on mental diseases for their own work as researchers and educators.[62] In a less spectacular way Skae's and Laycock's teaching affected many other medico-psychologists. According to the membership list of the MPA, between 1874 and 1885 about 21% of all medical officers of private and public asylums in Britain were graduates of the University of Edinburgh and likely attended one or both of the courses.[63] Both teachers left behind rich archives of lecture notes and didactic materials which allow us to reconstruct, compare and contrast their courses on mental diseases.

Between 1859 and 1873 David Skae and Thomas Laycock were in direct competition, as they both offered courses on medical psychology in Edinburgh. Laycock occupied the prestigious Chair of the Practice of Physic at the University of Edinburgh. His main responsibility was delivering a compulsory course on the practice of medicine. He also remained keenly interested in mental disease and the physiology of nervous system. At first he attempted to incorporate instruction on these subjects in his general course but, in 1859 he

[62] Beveridge 1991; Walmsley 1991; James 1996: 360–82.
[63] James 1996: 376.

started a separate elective course on medical psychology.[64] He taught both courses until his death in 1876.[65] Skae was the superintendent of the Royal Edinburgh Asylum and delivered an extra-mural course on mental diseases there every year from 1853 until his death in 1873.[66] The situation was not unusual: many of the medical subjects were taught at both, the University, and the extra-mural schools.[67] The students could attend lectures at either or both, according to their goals, needs and interests, especially on the subjects not compulsory for medical registration. The fact that the two courses survived alongside each other for over a decade indicates that there was considerable interest in insanity. There were three possible reasons for the popularity of the subject: the growing number of jobs in the asylum sector, the medical appointments in the East India Company requiring training on insanity, and better public and professional attitudes towards alienists in Scotland.[68] There are no indications that Skae and Laycock competed for students or poached them from one another. On the contrary, some of the students who set their hopes on an asylum career attended both courses, for instance Thomas Clouston who later became one of the most influential alienists in the country.[69] Therefore, when a controversy happened it was not about protecting the teachers' financial or professional positions, it was about the format and the content of their courses.

The core of the debate about instruction on medical psychology in Edinburgh was best summarised in the exchange between Laycock and John Batty Tuke in the "Correspondence" section in the *British Medical Journal* (*BMJ*) in early 1871.[70] Batty Tuke was one of the most prominent and vocal of Skae's students; he often defended Skae's theories and methods in press, hence it was not surprising that he took part in the debate on behalf of his teacher. The exchange was sparked by an anonymous letter criticising the asylum system and the separation of medical psychology from general medicine published in the *BMJ*.[71] Amongst other things its author claimed that the development of research and treatment of insanity was hampered by inadequate education on the subject. He argued that medical students should learn about mental diseases as part of their compulsory course on the practice of physic and should observe mental patients in teaching hospitals. He concluded by saying that "[b]efore any radical reform can be looked for, the student of medicine must have full opportunities afforded him of studying

[64] James 1996; Laycock 1861; 1995.
[65] James 1991: 261–76.
[66] Fish 1965; Barfoot 2009.
[67] Jacyna 1995.
[68] Crammer 1996; Scull 2011.
[69] Beveridge 1991.
[70] Laycock 1871a, 1871b; T. 1871a, 1871b.
[71] *BMJ*, 1, (1871): 199–200.

mental disease in all its phases."[72]

In the following issue Laycock responded by sharing his own views and experience of teaching medical psychology.[73] Although he agreed that instruction on insanity should become a compulsory part of medical education, he argued that it was "inexpedient" to include it in the course of physic. Laycock explained that the scope of medical psychology was broad enough to merit a separate course as it encompassed mental phenomena beyond "insanity […] as found in asylums" and demanded a thorough study of cerebral physiology and pathology.[74] He provided a syllabus of his course on mental disease calling it "essential, albeit a distinct" part of the course on clinical medicine:

> As to the course of Medical Psychology — 1. The first part of the course will comprise an exposition of the relations of psychology proper to the laws of life in general and the functions of the brain in particular. 2. Special forms of mental disorder will be treated in succession, commencing with the disorders of the animal appetites. This part of the course will be illustrated by cases and physiognomical photographs and drawings. 3. Sleep, dreams, and hallucinations will have a philosophical and practical consideration. 4. The laws and defects of memory (including attention) will be specially examined, and the pathology of the higher faculties, illustrated by numerous examples of the handwriting, composition, and art-products of the eccentric and insane (crazes and eccentricities are included in thus division).
>
> As to the course of Clinical Instruction in Mental Diseases: — This will be carried out at an asylum, where the diseases of the insane will be investigated and lectures delivered on special cases. (The students are practised in the drawing up of certificates of insanity). In the course of the summer the class will visit and study the management of a public asylum in Scotland or England.[75]

A reply by John Batty Tuke was printed in the next issues of the *BMJ*. Firstly, he pointed out that teaching medical psychology as a separate course with a "separate and distinct fee" made it unaffordable to many medical students.[76] Secondly, he argued that Laycock's syllabus was too wide and included unnecessary "occult metaphysical theories which have little or no bearing on practice". Batty Tuke suggested that the contents of the course should have been restricted to "simple descriptions of insanity as it exists as a bodily disease."[77] In this reply we could hear the echoes of Maudsley's ideas, as well as Skae's. This was the heyday of

---

[72] Ibid*:* 200.
[73] Laycock 1871a.
[74] Ibid.
[75] Ibid.
[76] T. 1871a.
[77] Ibid.

Maudsley's influence and his central notion that mental phenomena could only be scientifically understood "from physiological and pathological basis" was still in vogue.[78]

Laycock's rebuke came out two weeks later. In it, he claimed that by following Batty Tuke's advice, the teachers of medical psychology would have to "abandon all theory and science whatever."[79] He explained that a course on insanity had to cover the anatomy, physiology and pathology of the brain and "psychology based on observation of brain structure and function as applied to medicine".[80] In his interpretation, all of these would constitute "occult metaphysics" according to Batty Tuke. Omitting them, in Laycock's view, would make teaching of classification, diagnosis and treatment of mental diseases unfounded and unusable. Furthermore, he said that it would lead to continued shortage of scientific research at asylums and ultimately hinder the progress of medical psychology.

Batty Tuke remained unconvinced. In his response, he said that by conducting his extensive course Laycock "travels out of his proper sphere" like "a physician, who, in lecturing on dropsies, treats of hydrostatics".[81] Metaphysics and psychology ("alligator and crocodile", in Batty Tuke's opinion) might be interesting to some but they did not contribute to the solution of medical psychology's truly pressing problems: determining physical causes of insanity, discovering effective treatments and developing reliable principles of prognosis. He argued that it was the belief that metaphysics and psychology had anything significant to contribute to the medical study of mental disease that "seduced [inquirers] away from the truth" and held back the whole specialty.[82] According to Batty Tuke, most recent fruitful research in the area had been done by those who were "content to make the psychical subservient to the physical" and that this approach ought to be taught to students. He claimed that if he ever had to teach medical psychology he would follow the example of his teacher, David Skae, in whose "course of lectures, a most sagacious avoidance of metaphysics was observed, and a most sagacious application of logic was inculcated".[83] His proposition was supported by another correspondent, B. W., who suggested that "an intelligent and cultivated asylum physician, such as, for instance, Dr. Skae of Morningside" would be at least as good an instructor for a course on insanity as professor Laycock.[84] This debate then spilled over into other publications and

[78] *JMS,* 14 (1868): 149–62.
[79] Laycock 1871b.
[80] Ibid.
[81] B. J. T. 1871b.
[82] Ibid.
[83] Ibid.
[84] Laycock 1871b.

was recounted in the authors' further works.[85]

The tone of the correspondence between Laycock and Batty Tuke made it clear that they shared significant personal animosity. However, their short and dense exchange revealed much more than that. It highlighted profound differences in understanding what constituted scientific and practical teaching of medical psychology. The questions, concerns and arguments raised by the authors were characteristic of the problems of establishing scientific teaching on mental diseases in 1860s and early 1870s. Both, Laycock and Skae claimed that they were teaching and practicing scientific medical psychology, but their sciences had little in common.

First of all, Skae and Laycock disagreed about what made medical psychology scientific. Their opinions were heavily influenced by their own training and background. David Skae learned medicine at Edinburgh's extra-mural medial schools and in 1835 qualified by taking an examination of the Royal College of Surgeons of Edinburgh (RCSE).[86] He started lecturing on medical jurisprudence in 1836 and soon after was appointed an examiner in medicine at the University of St. Andrews.[87] The same university bestowed an honorary MD degree on Skae in 1842.[88] Hence, although technically he received a doctorate, Skae never had to engage in extended academic research. This might be one of the reasons why he published very little and never produced his own textbook or monograph. For Skae scientific approach to medicine in general and to medical psychology in particular had to be based on observation and recording of facts, quantification and inductive reasoning.[89] This approach was consistent with the very practical training he received as a student and the model of clinical medicine which dominated research and practice in the first half of the nineteenth century. Skae's scientific method of studying insanity, indeed, suited an asylum superintendent who in his daily work observed large numbers of patients, kept records and wrote reports which demanded quantification. In short, according to Skae, new scientific knowledge of insanity arose from analysing and generalising the data obtained in clinical practice.

Skae applied this approach in his work on the classification of mental diseases. He defined insanity as "a cerebral affection in which emotions, passions, or desires are excited by *disease* not by *motives* (moral insanity) or in which *conceptions* are mistaken for acts of

[85] For example, Laycock 1874a, 1874b.
[86] Fish 1965.
[87] Renvoize 1991; Fish 1965; Barfoot 2009.
[88] Fish 1965; Barfoot 2009.
[89] Barfoot 2009.

perception or *memory*".[90] He claimed that most contemporary classifications of mental diseases were inadequate and unscientific. In Skae's opinion, classifications based on symptoms were "as erroneous as it would be to classify fevers according to the kind of the delirium manifested in each."[91] Mental symptoms were a superficial sign of insanity and they varied patient to patient and changed in the same patient over the course of the disease.[92] According to Skae, the attempts to classify insanity according to pathology of the brain was not possible at the time, because the knowledge of it was not yet advanced enough.[93] Instead, he suggested his own "rational and practical" classification based on physical underlying causes.[94] He distinguished between predisposing causes, such as heredity, sex, age and education, and exciting causes. The latter could have been physical (For example, phthisis, childbirth and epilepsy) or moral (For example, excessive sexual activity in men and women, masturbation and alcoholism).[95] Skae argued that his classification was scientific and similar in method to botanical taxonomy. It relied on rigorous observation of patients in the asylum and careful collection of their histories from friends and relatives, identification of key aspects of their lives, quantification of the results and application of inductive reasoning to them.[96] Furthermore, he claimed that his approach was also practical because, if the cause of the disease was identified, it could be addressed in treatment and serve as a basis for accurate prognosis.[97]

Laycock's view of what constituted scientific medical psychology was radically different and also drew heavily on his own educational background. Unlike Skae, he trained first by apprenticeship and then moved to London to continue his medical training at UCL and to attend the wards of metropolitan teaching hospitals.[98] There Laycock came into contact with some of the most brilliant thinkers of the time: Robert Grant, Marshall Hall and Michael Faraday, to name just a few.[99] He was an intelligent student keen on natural sciences and, despite his strict Methodist upbringing, he deeply engaged with theories of evolution and relied on some of them in his future work. In 1834 he spent a session at the Medical School of Paris

[90] "David Skae's Lectures", LHSA, GD16/1/2/2, p.1, GD16/1/1/20 p. 29. Hereafter: *Skae's Lectures*.
[91] *Skae's Lectures*, GD16/1/1/20, p. 8.
[92] *Skae's Lectures* GD16/1/2/2, GD16/1/1/20; Skae 1863.
[93] *Skae's Lectures,* GD16/1/1/3, p. 22.
[94] Skae 1863: 309.
[95] *Skae's Lectures* GD16/1/2/2, GD16/1/1/20; Skae 1863.
[96] Skae 1863.
[97] Ibid: 319.
[98] Unless specified otherwise, the details of Laycock's early biography are taken from James 1996: 13–55.
[99] Robert Grant (1793–1874) – a famous comparative anatomist and transmutationist. He was a professor of zoology at UCL and one of Charles Darwin's mentors. Marshall Hall (1790–1857) – a well-known physiologist who developed the theory of the reflex arc. Michael Faraday (1791–1867) – a celebrated English natural philosopher and teacher on electromagnetism. *DNB*.

studying under such medical celebrities as surgeon and anatomist Alfred Velpeau (1795–1867) and gynaecologist Jacques Lisfranc (1787–1847).[100] He obtained a qualification at the Royal College of Surgeons in 1835, the same year as Skae. However, by that time Laycock developed a strong interest in academic research. In the following years he wrote prolifically on general medicine and published series of influential papers on hysteria and reflexes of the brain in the *Edinburgh Medical and Surgical Journal* in 1838, which were later published as a book titled *A Treatise on the Nervous Diseases of Women*.[101] He chose to obtain his MD degree in Germany at the Göttingen University, submitting his writings on hysteria as his doctoral thesis in 1839. In preparation for his doctoral defence, Laycock deeply engaged with contemporary German medical and philosophical literature. The scientific cultures of London and Germany had a profound influence on his future work.[102]

Laycock envisioned the scientific medical psychology as a "science of mind developed as a science of life".[103] Its main goal was to discover the laws which governed the work of mind and correlate them with the laws of life. According to him, the latter were the domain of biology and the former of mental science. In his system, medical psychology was a practical branch of mental science which dealt with mental diseases.[104] According to Laycock, "no change whatever arises in the consciousness without a corresponding change, or series of changes, of some kind in the organism," hence mental symptoms did not occur randomly but were always connected to the physical processes in a systematic way.[105] Laycock's methodology also differed from Skae's. For Laycock, observation and induction constituted only the first steps of the proper scientific inquiry; they produced generalisations, generalisations led to the discovery of laws, then the laws could be used for deductive reasoning to elucidate other phenomena or to guide new observations and experiments for higher inductions.[106] The discovery of laws was also of practical importance, as they would inform prognosis, treatment and prevention of mental diseases.

Laycock presented his approach in detail in his major work *Mind and Brain: Or the Correlation of Consciousness and Organisation* — a two-volume monograph intended both as a textbook for medical students and a systematic treatise on his method.[107] This work and the

[100] James 1996: 13–55; Laycock 1995: 6, 147.
[101] Laycock 1838a, 1838b, 1838c, 1838d, 1840.
[102] Danziger 1982; Brown 2011: 175–78.
[103] Laycock 1861: 1059.
[104] Ibid.
[105] Ibid.
[106] Laycock 1862a: 5.
[107] Laycock 1860.

first lecture of his annual course on medical psychology shed light on what gave rise to Batty Tuke's accusations of "occult metaphysics." On the map of contemporary knowledge Laycock situated scientific medical psychology between biology and metaphysics. Although, in his opinion, it needed to develop as an independent science, it could not "ignore the vast labours of the metaphysicians; [and] it must of necessity, take in all that biology has accomplished."[108] At least at first, this new science would best develop within medicine "the best material for the superstructure of a science of mind, since it demands definiteness and clearness as to principles and facts."[109] Therefore, a researcher or practitioner of medical psychology had to engage with mental processes (the domain of metaphysics), physical and physiological processes (the domain of biology) and the issues of health, illness and therapeutics (aspects of the "science and art" of medicine).[110]

Laycock's focus on the discovery of general laws, the formulation of unified theories as well as the significance he ascribed to both laboratory research and metaphysics were characteristic of German psychology and psychiatry.[111] In *Mind and Brain* and his other works Laycock cited German authors extensively, having become familiar with them through his doctoral studies. He also devoted a significant part of the textbook to the discussion of evolutionary theories and frequently referred to evolution and adaptation of organisms to the environment in his lecture course, citing Robert Grant, Thomas Henry Huxley and Charles Darwin.[112] This reflected the influences and connections which had remained from his time as a student in London. Even Laycock's terminology pointed towards his scholarly allegiances: he used "psychiatry" and "psychiatrist," which were widespread in German but rarely used in English, and his use of the word "biology" to denote a synthetic science of all living beings showed the connection to Huxley and the scientific approaches developing at UCL.[113] In contrast to Laycock, Skae referred to medical practitioners engaged in treatment of insanity only as "alienists" or "asylum officers" and the sciences which he proposed to use as a model for scientific medical psychology was natural history, which suggested connection to an older

[108] Laycock, 1861: 1059.
[109] Ibid.
[110] Laycock 1860 1: i–xvi; 2: 1–138, 1861.
[111] Danziger 1982; R. Smith 2013: 39–51.
[112] Laycock 1860 1: 356–81, 1861.
[113] The term "biology" in this meaning was introduced by T. H. Huxley in 1858 (Desmond 2001). It had not yet become widespread by 1861, thus, Laycock's use of the word suggests that he kept up with the work of London evolutionary scientists. It is also telling that he referred to Darwin in *Mind and Brain*, considering that the *Origin of Species* was published only a year earlier.

and more established British tradition, largely based on Pinel's and Prichard's work.[114]

3. The Edinburgh Pedagogical Controversy

Skae's and Laycock's approaches to scientific medical psychology were irreconcilably different. However, medical psychology in the 1860s and 1870s was a broad church and the lack of agreement on what made it scientific was one of its defining features. It was common for medical psychologists with divergent views to collaborate without too much tension. In fact, John Batty Tuke contributed a chapter to the third and fourth editions of Bucknill and Tuke's *Manual of Psychological Medicine*, even though the authors harshly criticised Skae's and his own classification and even claimed that an alienist

> must not only be a physician, but a *metaphysician*; not, indeed, in the almost opprobrious sense of this term, but in that better sense which designates a lover of truth, seeking to ascertain, not the essence of mind or any other unattainable abstraction, but *the laws of mind, which are as regular as any other natural law*.[115]

Why did Batty Tuke respond aggressively to Laycock's relatively insignificant comment in the *BMJ*, but did not take offence when a similar sentiment appeared in one of the most respected textbooks on insanity? A closer reading of the *BMJ* exchange reveals that the disagreement between Laycock and Batty Tuke was not just about what made medical psychology scientific but had a significant pedagogical dimension: they debated the best way of *teaching* scientific medical psychology. Conducting a course for medical students imposed certain constraints on the teacher. He had to:

1. fit all the necessary material into one teaching session;
2. set reasonable demands on students in terms of attendance and coursework;
3. adapt the delivery to the students' level of knowledge;
4. meet their expectations of receiving useful and applicable information.

Laycock prided himself on his teaching and devoted much of his time to systematising and presenting medical knowledge for didactic purposes: many of his published works were intended for students, and the notes he wrote in preparation for his lectures show signs of

[114] *Skae's Lectures* GD16/1/2/2, GD16/1/1/20; Skae 1863.
[115] Bucknill and Tuke 1874: 393. Emphasis mine.

regular revisions and additions of new material. He took part in discussions about improving medical education and often referred to his extensive teaching experience.[116] In the *BMJ* debate, he appealed to his authority as a teacher, saying that his opinion was based on "an experience of nearly a quarter of a century as a teacher" or claiming that Batty Tuke "would realise […] painfully if he had to teach" that psychological theories could not be avoided in the most practical course on mental diseases.[117] Batty Tuke, who himself had not taught students, called upon the authority of his own teacher — David Skae. Similarly, to Laycock, Skae was also proud of his pedagogical work. For example, he started his presidential address to the MPA by explaining that his teaching duties had not previously allowed him to attend the annual meetings and only the honour of being chosen the president forced him to leave his "usual course of lectures in a somewhat unfinished and hurried state".[118] Also, at the start of his lecture course on insanity in 1865, he introduced himself to the students as "the oldest lecturer at the Edinburgh Extra-Mural Medical School" with 27 years of teaching experience.[119] So both, Laycock and Skae, had strong and well-developed opinions on pedagogy that underpinned the content and structure of their courses. The differences in their approaches reflected the larger issues of teaching medical psychology in Britain.

First, Skae and Laycock had conflicting ideas about the content of an introductory course on insanity. They both claimed that their aim was to provide the students with systematic practical information on the subject which was accessible for a beginner.

In Skae's interpretation this meant focusing on the practice of diagnosis, treatment and management of insanity. His course took place at the Royal Edinburgh Asylum, lasted approximately three months and consisted of three clinical visits and a lecture per week.[120] He taught both a symptom-based classification, as it was more widely used in British asylums, and his own etiological one.[121] During their clinical visits, in addition to observing the patients, the students were encouraged to notice and ask the asylum officers about the practical arrangements of the institution: the architecture, regimen, actions of staff, furniture and other contraptions and so on.[122] Skae also briefly discussed some functions of a medical practitioner related to insanity outside of the asylum, such as giving testimony in court and diagnosing

[116] James 1996: 241–78, Brown 2011: 175–78.
[117] Laycock 1871a, 1871b.
[118] Skae 1863: 310.
[119] *Skae's Lectures,* GD 16 1/1/19, p. 1.
[120] *Skae's Lectures*, GD16/1/1/1; GD16/1/1/19.
[121] *Skae's Lectures,* GD16/1/1/19; GD16/1/1/20; GD16/1/1/27; GD16/1//2/; GD16/1//2/2. On Skae's use of standard classification in official records and his own in his notes see Jones 2019: 79–87.
[122] *Skae's Lectures,* GD16/1/1/3, p. 15.

insanity in private practice.[123] Skae devoted most of the course to the descriptions of different mental diseases and the discussion of typical cases. He emphasised the importance of scientific reasoning and research for treatment of the insane, claiming that the new asylums were effective because they were based on principles discovered by science.[124] However, he did not teach the students how to conduct scientific research, instead he focused on communicating to them the results of relevant scientific inquiries and the ways to apply them in the day-to-day medical practice.

As we glimpsed in the 1871 *BMJ* correspondence, Laycock abided by a different pedagogical approach. His course took place in the summer session at the University of Edinburgh and included approximately 40 lectures and weekly clinical visits to an asylum.[125] He started the course with the discussion of the main principles of scientific medical psychology and its place in relation to other sciences.[126] He then discussed "the laws of life in general and the functions of the brain in particular."[127] A large part of his course was dedicated to anatomy and physiology of the nervous system, the laws of mental processes (for example, memory and imagination) and "philosophical considerations" of mental phenomena (for example, dreams and hallucinations).[128] Laycock also taught his own theory of reflexes of the brain and its implications for understanding mental diseases.[129] In short, he discussed both normal and pathological mental functioning and connected them to general laws and theories. This approach, which seemed "occult metaphysics" to Batty Tuke, appeared the most constructive to Laycock himself who thought that there was nothing more practical than a good theory. His opinion was best summarised in the preface to *Treatise of the Nervous Diseases of Women* where he explained why he adopted a more theoretical and argumentative style than was usual for medical publications:

> I have often thought that treatises on the practice of Medicine professing to be free from theory, and to contain nothing more than a description of diseases, and the methods of treatment, are of

---

[123] *Skae's Lectures*, GD16/1/1/3.
[124] *Skae's Lectures,* GD16/1/1/19, p. 18, 21.
[125] Laycock 1871a; 1863: 445; "University of Edinburgh Medical School. Notes by William Carmichael MacIntosh (1838–1931)", University of St Andrews Special Collections, ms37106/17. Hereafter: *MacIntosh's Notes*. It appears that the number of visits and the asylums varied in different years. In 1860 the students visited Musselburgh Asylum, in 1863 — asylums in Milnholm and Dundee.
[126] Laycock 1862a, 1863; "Collection of Thomas Laycock", RCPE, DEP/LAT/1/34.
Hereafter: *Laycock's Lectures.*
[127] Laycock 1871a; 1861. *Laycock's Lectures* DEP/LAT/1/34.
[128] The archive of Laycock's lecture notes is extensive. I have summarised the contents of it, therefore I do not provide references to particular papers. *Laycock's Lectures* DEP/LAT/1 and DEP/LAT/2.
[129] *Laycock's Lectures,* DEP/LAT/1/34.

> questionable utility. The condensed style in which they are usually written, admits of no detailed exposition of the principles laid down, or the facts from which these principles are deduced. […] Scientific medicine has much wider range of immediate practical usefulness and prospective benefit than this mere practical medicine. Its rules are less applicable to individual diseases, than to the infinite variety of individual cases.[130]

The same principle guided Laycock's design of the courses on mental diseases. He endeavoured to teach the principles of scientific thinking and the general laws and relationships between the mind and brain. Laycock reasoned that his students would be able to deduce the application of this general knowledge to specific problems in their future practice in a confident and flexible manner.[131] His way of teaching was not to every student's taste. George Matthew Robertson, the Physician Superintendent of the Royal Edinburgh Hospital, in his recollections of the student years under Laycock's tutelage, wrote:

> He spoke as if it were water being poured out of a bottle wrong side up, sometimes the material coming in floods and irregularly. No student below the age of 20 to 25 had read sufficiently to follow and appreciate the most excellent material given in his lectures.[132]

Although Laycock was sometimes criticised for his too theoretical and inaccessible approach, the evidence suggests that his course also covered plenty of concrete applicable material. Like Skae, he discussed different mental disorders, their symptoms, treatment and prognosis. His lecture notes contained many cases from resent medical publications, his own observations at the asylums or cases sent to him by other asylum doctors. He showed his students the writing and art created by the asylum patients and discussed relevant unusual occurrences published in popular press. For example, there was a note and a couple of newspaper clippings about Greyfriars Bobby attached to his lecture on animal behaviour and evolution of human emotions.[133] In 1862 he delivered an entire lecture based on a recent scandalous court case and attached a whole collection of clippings from newspapers and medical press about insanity pleas and insanity amongst criminals to the lecture titled "Philosophy and Faults of Ethics and Law."[134] This was all in addition to the clinical visits to an asylum where the students learned about diagnosis and treatment of insanity, interacted with

---

[130] Laycock 1840: vii–viii.
[131] Laycock 1871b.
[132] [Biographical Notes on Thomas Laycock Collected by George Matthew Robertson], LHSA, GD16/Box 19, p. 6. Hereafter: *Biography of Laycock.*
[133] Laycock's Lectures, DEP/LAT/1/52.
[134] Laycock 1862b, Laycock's Lectures, DEP/LAT/1/57; DEP/LAT/1/51.

the asylum staff and patients and were introduced to the practical aspects of asylum management.[135] The questions for the exam at the end of the course were also mainly focused on practical aspects of medical psychology: descriptions of specific forms of mental disease, principles of diagnosis and treatment, education of idiots, the official procedure of diagnosing insanity and precautions related to this procedure.[136] The students also examined an asylum patient as a part of their examination and filled in a certificate of insanity.[137] Hence, even though Laycock ascribed more importance to general theoretical knowledge, his course also included practical skills.

Laycock and Skae differed on how they envisioned the target audience of their teaching. Both courses attracted similar numbers of students per year: Laycock carried out a course for about 30 students once a year, Skae conducted his class twice a year for groups of 12–15 students.[138] Although the available evidence suggests that in reality their courses were attended by very similar audiences consisting of medical students who wanted to learn more about insanity for different reasons, each of the teachers conceptualised their audience differently.

Skae thought of his students, first of all, as future general practitioners. He assumed that the majority of them would employ their knowledge of insanity in private practice.[139] He encouraged them to consider a position in an asylum, emphasising that superintendents of county asylums have "an income between £400 and £800 per annum" which was a comfortable sum, not always attainable in a small private practice but did not expect that many of his students would choose asylum practice as a career.[140] Thus, Skae's course was designed to cater mainly to the future private practitioners who, in his opinion, had to be able to diagnose insanity at early stages, provide preventative care and treatment to patients at home when it was possible, make the decisions on transferring patients to the asylum, sign certificates of insanity and testify in court.[141] Those, who wanted to embark on a career in the asylum system, according to Skae, would need additional training, so it would behove them to take a position of an assistant first, to gain more knowledge and skills under the supervision of an experienced alienist.[142] In his lectures he stressed that medical practice had to be informed by science but did not attempt to instruct the students on how to conduct their own inquiry. According to him

[135] *MacIntosh's Notes,* ms37106/17.
[136] Laycock, 1863: 444.
[137] *MacIntosh's Notes,* ms37106/17; Laycock 1863.
[138] Laycock 1871a.; *Skae's Lectures,* GD16/1/1/2, p. 2.
[139] *Skae's Lectures,* GD16/1/1/3, p. 2.
[140] *Skae's Lectures*, GD16/1/1/19, p. 20.
[141] *Skae's Lectures,* GD16/1/1/3, p. 2.
[142] *Skae's Lectures,* GD16/1/1/19, p. 19–20.

this was more appropriate for a postgraduate level, hence he encouraged his assistants to conduct and publish their research, but not undergraduate medical students.[143]

In contrast to Skae, Laycock conceived of his audience as future researchers of insanity. Therefore, his course was designed to cater to the needs of developing scientists who would advance medical psychology in the future. He attempted to instil in them foundations of scientific thinking and practice. In the preface to *Mind and Brain* Laycock explained that, by systematically describing the research method and fundamental doctrines of medical psychology, he created "a guide through the multitudinous phenomena he [an earnest student] has to examine and compare, in his scientific progress from the known to the unknown".[144] In 1863, to encourage the students in their studies of the subject, Laycock together with the Royal Crichton Asylum organised a competition for the exam papers with a possibility to win a monetary prize.[145] The papers were examined by James Coxe and W. A. F. Browne — both renowned Edinburgh alienists. Robertson judged that

> [w]hat he [Laycock] was teaching us is what we now call a post graduate [sic] course, and although when he treated on a common subject, his teaching might be quite ordinary and agree with textbook teaching, in many instances his treatment was very superior to that found in any textbook.[146]

Robertson noted, that Laycock was a much more popular teacher on medical psychology than on the practice of physic, which, he explained, was due to differences in the audiences. Since the course on mental diseases was not compulsory, it was attended only by interested and motivated students, who were willing to engage with more challenging material.[147]

Another issue the debate between Laycock and Batty Tuke brought to the fore was who ought to teach medical psychology. Should it be the duty of a "teacher of practice of physic" to introduce the students to mental diseases, as the anonymous initiator of the debate suggested?[148] Or would it be better if a "cultivated asylum physician" taught his own specialism?[149] The implications of this problem extended far beyond the alienists' community. One of the characteristics of British medicine as a whole in the nineteenth century was its persistent resistance to medical specialisation.[150] Both the rank-and-file practitioners and the

---

[143] Beveridge 1991: 362.
[144] Laycock 1860 1: xi.
[145] Laycock 1863.
[146] *Biography of Laycock,* p. 7.
[147] Ibid.
[148] *BMJ*, 1 (1871): 200.
[149] T. 1871b.
[150] We will discuss the problems with specialisation further in the following chapter. For more on British history

elites considered specialisation as a threat to the unity of the profession. They argued that an already heterogeneous and fragmented medicine would disintegrate with the addition of formally recognised specialisms. Furthermore, the prevailing opinion was that narrow specialisation would be detrimental to medical care as a good practitioner had to treat the patient as a whole and be aware of the intricate interconnections of different organs and physiological functions. However, this hostile climate did not prevent specialisation, it just altered its development compared to the examples of Continental Europe. In Britain, specialisation was camouflaged and specialists were presented as "only generalists who through training and experience acquired special expertise that was recognised by their peers and that did not necessarily imply exclusive practice in a special field."[151] In this context the discussion about who would be the most appropriate teacher on mental disease — a professor of medicine or an asylum superintendent — was difficult to navigate and could leave the participants in danger of disapproval from the wider medical community.

The original suggestion, which provoked the exchange between Laycock and Batty Tuke, was for a teacher of practical medicine to include insanity into the general course of practice of physic.[152] As it was a compulsory subject for all medical students, it would ensure that all new practitioners would become familiar with the basics of medical psychology. Furthermore, it would reinforce medical psychology's status as an area of medicine and emphasise equal importance of treating physical and mental illnesses. The obvious drawback of this plan of action was that the course on practical medicine was already extensive and could accommodate only very limited teaching on insanity. Moreover, teaching hospitals still did not accept mental patients, hence students would either not receive any clinical instruction on insanity or the teacher had to arrange separate clinical visits to a nearby asylum in addition to hospital training. It is understandable, why Laycock called it "inexpedient".[153] His suggested alternative was to teach a separate non-compulsory course on medical psychology, but still keep it as a responsibility of the teacher of practical medicine at a university or a medical school. For the majority of the profession who was against the spread of specialisation, this solution was still acceptable. Having a generalist teach on insanity as an aspect of medicine would bolster the view that a truly competent practitioner had to be proficient in all areas of medicine, not just to choose one and dedicate all his practice to it. It also helped to maintain

---

of medical specialisation and its relationships with similar processes in other countries, see Weisz 2003, 2006.
[151] Weisz 2006: 43; Casper and Welsh 2016.
[152] *BMJ*, 1 (1871): 199–200.
[153] Laycock 1871a.

the authority of the contemporary medical elite as it consolidated all teaching in the hands of practitioners affiliated with a particular school or university.[154] On a more practical level, amongst the advantages of the lecturer on practical medicine were teaching experience, good understanding the students' needs and the ability connect mental diseases to other areas of the curriculum. Laycock, explaining his own pedagogical position, drew attention to his extensive teaching experience which informed his decision to teach medical psychology in a separate course and to include some general psychology and physiology in its content.[155] He also emphasised the importance of understanding mental symptoms for other areas of medicine, as they were indicative of many other bodily conditions, such as diabetes, fever or pregnancy.[156]

On the other hand, there were persuasive arguments for preferring asylums medical officers as instructors on insanity. First of all, they had abundant practical experience of dealing with the insane. Many alienists themselves did not welcome medical specialisation and agreed that particular expertise did not have to come from exclusive specialist practice. However, the contemporary lunacy system dictated that to gain an extensive experience of treating the insane one was obligated to spend at least some time practicing at an asylum, simply because there were no other medical institutions which accepted sufficient numbers of mental patients. Furthermore, alienists also were well-placed to judge what was necessary and most useful for student to learn to be able to work in an asylum. Batty Tuke in his criticism appealed to Laycock's lack of asylum experience and praised Skae's approach as informed by extensive practical work with the insane.[157] Although it sounded rational, this line of reasoning was also a dangerous one as it could be read as support for specialisation. There also were political reasons for asylum doctors to try to gain control over teaching medical psychology. Teaching a course at a medical school or being affiliated with one provided asylum medical officers a route to prestigious consultants' appointments or private practice outside of the asylum system.[158] Moreover, it would support alienists claim to superior knowledge about mental disease through an acceptable means of peer recognition. In many ways alienists' arguments for preferring the asylum superintendents as instructors on insanity were not to increase specialisation, but for the opposite purpose — to make medical psychology more integrated into general medicine.

The final point of contention was the choice of the most appropriate site for scientific

[154] Weisz 2006: 33; Casper and Welsh 2016.
[155] Laycock 1871b.
[156] Laycock 1871a, 1861; *Laycock's Lectures*, DEP/LAT/1/34.
[157] T. 1871b.
[158] Oppenheim 1991: 25.

teaching of medical psychology. Both, Laycock's and Skae's courses were of similar length and included clinical instruction and lectures, however, the relative weight of each form of training in their courses was different. Three quarters of Skae's course were devoted to clinical visits and only a quarter to lectures.[159] His main site of teaching was the asylum ward where the students could experience first-hand the daily functioning of the institution, treatment of the patients and behaviour of the asylum's staff. The function of the weekly lectures was to clarify, systematise and generalise the student's clinical experience. The ratio of lecture room teaching to clinical instruction in Laycock's courses was reversed: of about 40 classes in total, only 10 or so were clinical visits to asylums.[160] In accordance with the core of Laycock's pedagogical approach, the main site of his teaching was undeniably the university classroom, as it was the most appropriate space for instructing students on complex theories and laws of mental functioning. The clinical visits were important, but mainly as an opportunity to apply in practice the theoretical knowledge gained in the classroom. Both approaches had their proponents and opponents, who put forth arguments in support of their views.

Those who preferred clinical teaching in the asylum ward claimed that students who spend more time at an asylum would be better prepared for the reality of asylum work and would have more practical knowledge and better diagnostic judgement. They would also learn a good work ethic from the "real hard workers amongst asylum physicians" and later emulate it in their own practice.[161] The students, who spend the majority of training in a classroom, would be too involved in the discussions of some "very pretty subjects" like psychology and metaphysics, instead of learning about things which were actually important: the physical causes and signs of insanity, effective treatments and optimal management of an institution for the insane.[162] In his letters, Batty Tuke, who favoured asylum training, stated that "the fancy university professors who fancy themselves knowledgeable about insanity and their students wouldn't last a day in an asylum."

The proponents of teaching about insanity mainly in the classroom, preferably at a university or an established medical school, argued that the students who learned this way would acquire the most recent and fundamental scientific knowledge. They would learn objective and general information, rather than the quirks and preferences of a specific asylum superintendent. Moreover, as Laycock pointed out "insanity, in the restricted sense of the term,

---

[159] *Skae's Lectures,* GD16/1/2/2, GD16/1/1/20.
[160] *MacIntosh's Notes,* ms37106/17.
[161] T. 1871b.
[162] Ibid.

and as found in asylums, is only one of [the] divisions" of medical psychology, therefore training carried out mainly in the wards would only cover a part of the subject.[163] He also claimed that "the reciprocal relations of body and mind" were so essential to understanding mental disease "that accurate observation of the causes of disease, and of the effects of remedies is not possible without sound knowledge of these relations."[164] In other words, there would be no benefit from extensive clinical instruction without prior knowledge of the scientific theory. Furthermore, in the classroom the students could learn not just of the scientific discoveries but also of how these discoveries were made. This information together with a firm grasp of the scientific method, also more conveniently taught in a lecture room setting, would likely inspire students to conduct their own research and arm them with all the instruments needed to do it. On the other hand, the asylum superintendents and their assistants were often too bogged down in the day to day practical operation of the institution that they were ignorant of latest advancements in their field and did not contribute "their proper quota of scientific knowledge" and, therefore, rarely inspired scientific zeal in their students.[165] To support his assertion that a good theoretical and scientific education in a classroom would serve the students well in the asylum, Laycock reminded that some of his students went on to become asylum superintendents and were performing their duties well "because of their scientific training."[166]

The fiery discussions about the relative merits of academic education and practical education "in the field" were not restricted to medical psychology. In medical education as a whole there were tensions about defining the role of clinical and laboratory training.[167] The education on the sciences also required more of the students' own engagement in the experimental laboratory work, but there were still reservations about the amount of practical scientific education needed to produce competent medical practitioners. Beyond medicine similar controversies arose in technological and industrial education.[168]

Both Skae and Laycock claimed that their courses were systematic, practical and introductory, however, the analysis of their teaching illuminated the differences in their interpretations of these words. The *BMJ* debate touched upon many pressing issues in mid-Victorian professional and academic education. The situation was incredibly complex, and no

[163] Laycock 1871a.
[164] Ibid.
[165] Laycock 1871b.
[166] Ibid.
[167] Bonner 1995: 251–79.
[168] Gooday 1991b; 2005.

ready answers emerged from these discussions, however, another British alienist attempted to offer a different system of training which would incorporate the advantages of both, Skae's and Laycock's, approaches and add further components to increase the legitimacy of scientific medical psychology.

4. Scientific Asylum, Laboratory Research and Proto-Postgraduate Training

Lunatic asylums as sites for scientific research and teaching had a controversial reputation. Some alienists claimed that asylums were perfect for these purposes, as they offered ample opportunities for both. Others held the opposite view, pointing out that the overcrowding of the wards, the burden of superintendents' administrative work and the alleged shortage of scientific knowledge produced in the asylums made them impractical institutions for research and training. A renowned alienist, James Crichton-Browne, the superintendent of the West Riding Lunatic Asylum from 1866 until 1875, proposed a system which would reassure people on both sides of the controversy. He transformed a large county asylum under his care into a state-of-the-art research centre of national importance. Simultaneously, Crichton-Browne worked on establishing his institution as a centre for education on mental disease. The asylum offered two forms of teaching: an annual undergraduate course for the students of Leeds School of Medicine (LSM) and three-months-long clerkships for qualified medical practitioners, who wished to advance their knowledge of insanity.

James Crichton-Browne (1840–1938) was a son of an eminent Scottish alienist W. A. F. Browne and an enthusiastic student of Laycock.[169] He embarked on an asylum career right after he completed his training. Between 1863 and 1865 he served as an assistant medical officer at several asylums and was a superintendent of the Newcastle upon Tyne asylum for a year in 1865.[170] In 1866 he was appointed superintendent of the West Riding Lunatic Asylum in Wakefield — one of the largest county asylums in Britain, which held 1118 patients at the time.[171] The competition for the post was steep: Crichton-Browne and seven other candidates were selected for an interview, amongst them was Thomas Clouston, a fellow Edinburgh graduate and Laycock's student.[172] At the time of the interview all eight candidates were employed at lunatic asylums and five held MD degrees. The job was worth competing over: it

[169] Crichton-Browne 1861: 20–21.
[170] *DNB*.
[171] Finn 2012: 83.
[172] "Minute Book of the Committee of Visitors, 1857–1880", WYAS, C85/1/1/3, 19 July 1866. Hereafter: *Committee of Visitors Minutes*.

brought an annual income of £500 (increased to £600 from 1871) plus free housing and laundry.[173] A senior medical officer at the same asylum received £125 per year and room and board on the premises, and an assistant medical officer was paid £100 with the same additional benefits.[174] Therefore, for a practitioner who served as a medical officer of another asylum this would be a step up financially as well as in terms of prestige. As Crichton-Browne was already a superintendent of an asylum at the time, albeit a much smaller one, the increase in his salary would not have been as drastic but being put in charge of a large institution with supportive magistrates provided additional advantages.

As soon as Crichton-Browne stepped into his new role, he commenced on transforming the West Riding Asylum into a scientific institution. In early 1867 he remarked that "the unparalleled facilities which they [asylums] offer for the study of nervous and mental diseases have not yet been taken advantage of as fully as could be desired" and offered his suggestions on how to remedy the situation.[175] He also articulated that it was in the magistrates' and public interest to fund facilities and create opportunities for research at the asylums. In the 1860s and 1870s the number of institutionalised pauper lunatics grew rapidly which constantly demanded the extensions of existing asylums and the building of new ones.[176] It was a costly process which did not cause any visible effects: the rates of cure at the asylums remained low. Crichton-Browne argued that

> The true method of meeting our difficulties […] is undoubtedly to be found in the application of medical science, to the cure and prevention of mental diseases. Something more remains to be done, beyond the mere provision of commodious quarters for our increasing number of lunatics. […] We must insist that asylums should become hospitals more and more; and should subordinate safe custody and comfortable lodging, to cure and scientific exploration: for it is but reasonable to hope that a careful, sustained, and general inquiry into the cases, pathology, and treatment of mental derangements, would multiply our resources and give precision to our efforts in dealing with them, and enable us to warn against circumstances that conduce to create them, and to guide to prophylactive [sic] measures.[177]

However, in order to allow medical officers to conduct research and provide appropriate treatment and care to the patients, it was imperative to introduce changes into the

---

[173] *Committee of Visitors Minutes*, 24 July 1866; 27 April 1871.
[174] Ibid: 31 January 1867; 31 October 1867; 30 January 1868; 25 July 1872.
[175] "Report of the Medical Superintendent", 24 January 1867, WYAS, C85/1/12/2, p. 23.
[176] Scull 1993: 267–333.
[177] "Report of the Medical Superintendent", 28 January 1869, WYAS, C85/1/12/3, p. 27.

running of the asylum. First of all, there had to be sufficient and adequately trained staff. To that end, Crichton-Browne introduced the short-term unpaid position of clinical clerks to be occupied by registered medical practitioners with an interest in mental disease. Their work and purpose will be discussed later in this section. He also suggested that the asylum should have its own pathologist, and finally received the magistrates' approval for this in 1872.[178] The asylum nurses and attendants also received informal but thorough training on the job and were expected to assist with the research activities:

> [a]t the visits of the Medical Officers or Clinical Clerks, the Charge Nurse for the time being shall accompany them through their respective Wards, Day-rooms, Dormitories, &c., and shall describe to them every peculiarity in the condition of each Patient. They shall give full and explicit information concerning the bodily and mental condition of the Patients, and the effects of remedies, occupation, &c., upon them. They shall also carefully assist in any scientific investigation that it may be desired to carry out.[179]

Secondly, there was a need for special research facilities: a pathological and a histological laboratory, a museum with pathological specimens and images, and a photography studio.[180] All of these were established in the West Riding Asylum in the early 1870s.[181] Thirdly, to become a thriving scientific centre, the asylum had to attract researchers to conduct investigations in the laboratories and asylum wards. Crichton-Browne excelled at accomplishing this task. He did not only engage in his own research and encourage other asylum medical officers do the same but also welcomed external practitioners to utilise the asylum facilities for their work. During Crichton-Browne's superintendency several celebrated researchers gathered data in the Wakefield asylum's wards and carried out experimental investigations in the laboratories, for example, neurologists David Ferrier (1843–1928) and John Hughlings Jackson (1835–1911), physicians Thomas Clifford Allbutt (1836–1925) and John Milner Fothergill (1841–1888) and physician and pharmacologist Thomas Lauder Brunton (1844–1916).[182] Another famous name associated with the Wakefield asylum was that of Charles Darwin, who collaborated with Crichton-Browne in the research leading to the 1872

[178] "Report of the Medical Superintendent", 30 January 1873, WYAS, C85/1/12/3, p. 27.
[179] West Riding Lunatic Asylum 1873: 19–20.
[180] On the functions of a pathology laboratory and practice of post-mortems at lunatic asylums see Cullen 2017; Andrews 2011; C. Smith 2011. On the use of photography in asylums see Sidlauskas 2013; Rawling 2021a, 2021b, 2017; 2011; Bressey 2011; Plessis 2015; Pichel 2016; Green-Lewis 1996: 145–86; Godbey 2000; Gilman 1988; Jackson 1995.
[181] Finn 2012: 75–78. For a detailed discussion of the investigation of the body at the West Riding Lunatic Asylum see Wallis 2017a, 2017b.
[182] Finn 2012: 70–83; Todd and Ashworth 1991: 393–401.

book *Expressions of the Emotions in Man and Animals.* The alienists' contribution was in a form of 41 photographs of the asylum's patients with detailed notes on each person's behaviour and diagnosis.[183]

Finally, it was crucial for Crichton-Browne's programme that there had to be opportunities for sharing and discussing the results of the research. To that end, he established a new periodical publication — the *West Riding Lunatic Asylum Medical Reports* with the hope that it

> will lead to the utilization of the valuable materials, which are being constantly collected in our Registers and Case Books, and will enlarge our knowledge of mental and cerebral diseases […]. I am sure they will incite the Medical Officers of the Asylum, […] to investigate and observe, with closeness and accuracy the phenomena which come before them in their professional work.[184]

The entire journal was dedicated to the publication of original research on mental diseases and the physiology and pathology of the nervous system and, therefore, provided a quick and easy way for the Wakefield researchers to publish their work. The *Reports* came out annually from 1871 until 1876 and attracted praise from medical and lay press.[185] Furthermore, between 1872 and 1875 the asylum hosted annual conversaziones — "social gatherings of polite erudition, education and entertainment which were very popular in the Victorian period."[186] The events were attended by both medical and lay audiences, who came to listen to an invited speaker, inevitably a scientist of some renown, and observe experiments, anatomical specimens, photographs, illustrations and other fruits of the scientific labour at the asylum.[187] The invited speakers included Francis Anstie (physician at the Westminster Hospital), William Turner (the Edinburgh anatomist), William Carpenter (physiologist and naturalist at UCL), William Broadbent (physician at the St Mary's Hospital in London) and John Charles Bucknill (famous alienist and author on insanity).[188] The conversaziones were covered in local and national press and attracted impressive audiences, for example, as in 1873 when "nearly 300 medical men" were present.[189]

Despite becoming a thriving centre for scientific research, the West Riding Lunatic

---

[183] Finn 2012: 109. On the collaboration between Darwin and Crichton-Browne and on how Darwin used photographs as scientific evidence in his work see Pearn 2010; Browne 1985, 1986; Prodger 2009.
[184] "Report of the Medical Superintendent", 25 January 1872, WYAS, C85/1/12/3, p. 29.
[185] Finn 2012: 80.
[186] Finn 2012: 145.
[187] Todd and Ashworth 1991: 401–02; Finn 2012: 144–51.
[188] Todd and Ashworth 1991: 401.
[189] "Report of the Medical Superintendent", 29 January 1874, WYAS, C85/1/12/3, p. 25.

Asylum did not cease to be a functioning institution for treatment of insanity. Furthermore, in the years of Crichton-Browne's superintendency the amount of day-to-day clinical and administrative work was steadily increasing with the growing numbers of patients which rose from 1118 in 1866 to 1416 in 1875.[190] Unlike many of his contemporaries, Crichton-Browne did not see the necessity to treat patients as an obstacle or detraction from scientific research. On the contrary, according to him the clinical functions of the asylum were essential for the production of new knowledge: the patients and their reactions to various treatments offered valuable observations, the large numbers of lunatics in the asylum allowed to generalise those observations, and, the unfortunate cases when patients died provided opportunities for anatomico-clinical correlation.[191] He claimed that "original inquiry and experiment" led to best results "when they are combined with that modest philanthropy and laborious routine work, which ought to form the staple of his [asylum medical officer's] daily life."[192] This view of scientific inquiry growing out of every-day clinical work explained why, regardless of all associated difficulties, the asylum was the best institution for research on mental and neurological diseases, not universities, medical schools or private laboratories. Moreover, Crichton-Browne's approach to treating insanity was not affected by the therapeutic pessimism widespread in the alienists' community at the time. In his reports to the asylum visitors, he proudly stated:

> we have not been affected here by the paralyzing influence of that scepticism as to the usefulness of remedies which has been fashionable of late. On the contrary the results of our daily trials and observations, stimulate us to more vigorous therapeutic efforts, and convince us more of the curability of insanity by medical agents.[193]

All of the above demonstrates that Crichton-Browne was by no means uncritical of the existing asylum system and its faults and difficulties but at the same time, he remained optimistic about its potential. He used the example of the institution under his superintendence to create a model of a scientific lunatic asylum where new knowledge about mental diseases was discovered and promptly applied to therapeutic practice. Moreover, Crichton-Browne opened this model institution to medical students and newly qualified practitioners, eventually providing other asylums with new cadres trained in his approach.

---

[190] Finn 2012: 83.
[191] Finn 2012: 89–133.
[192] *WRLAMR*, 1 (1871): iv.
[193] "Report of the Medical Superintendent", 28 January 1869, WYAS, C85/1/12/3, p. 33.

An undergraduate course on mental disease was arranged in collaboration with the nearby Leeds School of Medicine. In March 1868 Crichton-Browne approached Thomas Clifford Allbutt, a successful local physician and lecturer on *materia medica* and comparative anatomy at the LSM, with a suggestion of "a most liberal programme — delivering of 6 lectures at the School — [and] holding a weekly clinique at the Asylum."[194] The LSM Council accepted this proposal enthusiastically, decided that the first course would be run during the coming summer session and set out "to draw up a list of those students who in the opinion of the Council are fitted to take advantage of this opportunity."[195] The arrangements proceeded swiftly and on 31 July 1868 the Council "resolved that the vote of thanks be paid to Dr Crichton Browne for his kindness in delivering a Course of Lectures in Mental Diseases during the past session."[196] The following offer from Crichton Browne to repeat the course in the future was accepted by the council and the courses continued annually even after Crichton Browne left the Wakefield asylum in 1876.[197]

The remarkable ease with which the instruction on mental diseases and the collaboration between the medical school and the asylum were established can partly be explained by the fact that it did not interfere with the LSM teachers' financial interests. The course was free for the students and Crichton-Browne did not demand payment from the school for his services. Moreover, at least in the first year, the superintendent used free food as an additional incentive to attend clinical visits promising "provision of luncheon to the class going over to Wakefield, provided […] students were select and not too numerous."[198] Not having to share student fees was one of the perks of working with a public asylum superintendent, as he already had a stable income and the lunacy law prohibited him from taking other employment in addition to his duties at the asylum. Nevertheless, the collaboration was beneficial for Crichton-Browne too. It helped him integrate into the local medical community: he attended the LSM annual dinners at the Scarborough Hotel in Leeds with the rest of the faculty and was invited to other formal functions at the school. In turn, many of the LSM teachers came to the conversaziones and utilised the West Riding Lunatic Asylum facilities for their research.[199] Teaching a course on insanity also attracted good will from the medical community, generated positive publicity and helped to justify the need for scientific facilities.

---

[194] "Leeds School of Medicine Minutes of Council, Vol. IV, 1860–1885", University of Leeds Archive, LUA/DEP/001/7, p. 97. Hereafter: *LSM Minutes of Council, 1860–1885*.
[195] Ibid.
[196] Ibid: 101.
[197] Ibid: 102.
[198] Ibid: 97.
[199] *LSM Minutes of Council, 1860–1885:* 135–36; 140; 150; 161; Finn 2012.

Under Crichton-Browne, the courses were attended on average by eighteen students each year.[200] Several of his lectures were published in the *BMJ* between 1871 and 1874 and offer insight into his pedagogical method.[201] Each lecture started with a short theoretical overview of the day's topic (a particular mental disorder). Then Crichton-Browne presented characteristic cases from the Wakefield asylum, including the patients' history, symptoms, behaviour, reaction to various treatments and findings of the post-mortem investigations for the patients who died. He also employed pathological specimens and photographs to illustrate the lecture material.[202] For example, in the lecture on the cancer of the brain he invited the students to examine specimens of a brain, lungs and lymph nodes "taken from the body of a male patient who died recently in this asylum."[203] Finally, the third part of each lecture was dedicated to the discussion of treatments and their efficacy. There Crichton-Browne also relied on the material gathered in the asylum and offered detailed discussions of the patients' reactions to various medications, diets and procedures. Although some treatments were purely palliative, for example, in the cases of brain cancer or dementia, in the lectures Crichton-Browne stayed true to his conviction that mental disorders could be cured by medical agents. For instance, he suggested bromide of potassium, valerian, asafoetida and morphia for mania; cod-liver oil and hypophosphite of sodium for "brain-wasting" and muriate of ammonia and opium for melancholia.[204] In the undergraduate lectures Crichton-Browne focused on communicating contemporary scientific information of mental diseases, their diagnosis and treatment, and directed the students' observations of clinical cases and specimens. However, the students did not themselves engage in scientific research and did not discuss in detail what constituted scientific inquiry.

These advanced topics were left for qualified medical men interested in extending their knowledge about insanity. For this type of learner, Crichton-Browne established a less formal programme of training in the shape of unpaid clinical clerkships. These positions were approved by the asylum governors in April 1867 and offered room, board and instruction to the clerks in return for routine medical work in the wards.[205] The asylum could employ two clerks at a time, and they usually stayed for a period between three to six months. Their duties

[200] *LSM Minutes of Council, 1860–1885:* 163.
[201] Crichton-Browne 1871–1874.
[202] For a detailed discussion on the uses of visual culture in medical education see Rawling 2017, 2021b; Berkovitz 2012; Beveridge 2018; Kemp 1993; Jordanova 1990, 1993; Jackson 1995; Kusukawa 2012; Richardson 2008; Palfreyman and Rabier 2017; Gilman 1988; Danston and Galison 2010; Reinarz 2005.
[203] Crichton-Browne 1871–1874: 425.
[204] Ibid: 468, 146, 431.
[205] Crichton-Browne 1869: 601–02.

included careful observation of cases in the wards, keeping detailed clinical records and obtaining additional information on some cases, when directed by the medical officers. The clerks were required to attend and assist in all post-mortem examinations, "surgical operations of scientific investigations that may be in progress in the Asylum during the period of their residence there."[206] The clerks were also allowed to carry out their own scientific research under the supervision of experienced medical officers, encouraged to publish the results in the *West Riding Lunatic Asylum Medical Records* and had an opportunity to present some of their work at the conversaziones.[207]

I consider these clerkships a form of proto-postgraduate training rather than medical employment for several reasons. First of all, these positions were unpaid and short-term. Secondly, they were created with two specific goals in mind: to assist in the scientific work of the asylum and to undergo "the best preparation for subsequent Asylum appointments, or even for general practice."[208] Historian Mike Finn remarked the similarity between clerkships and another form of training — medical apprenticeships.[209] Indeed, the goals and pedagogical methods were the same in both. There was, however, an important difference. Unlike the early-nineteenth-century apprenticeships, the clerkships could only commence after full medical registration, as they entailed provision of medical services to the patients. Moreover, there were obvious similarities to the academic postgraduate training in later periods: conducting research, publication in professional journals and presenting their work to medical colleagues. This was also one of the few ways of acquiring a medical specialisation within the specialisation-resistant British medical community of the 1860s and 1870s. It was safely camouflaged as extra training and experience for general practitioners with no academic diplomas, degrees or requirement to practice solely as alienists afterwards.

Nevertheless, other medical practitioners and especially asylum superintendents recognised West Riding Lunatic Asylum clerkships as evidence of particular competence. Out of the known 33 clinical clerks who trained under Crichton-Browne 26 subsequently secured employment in asylums or other lunacy-related medical roles.[210] Many of the men who started out as clinical clerks in Wakefield, continued to assistant medical officer's appointments at the same institution and two, Herbert Major and William Bevan-Lewis, became superintendents

[206] Ibid: 601.
[207] Finn 2012: 72–74, 178–88.
[208] Crichton-Browne 1869: 600; "Report of the Medical Superintendent", 28 January 1869, WYAS, C85/1/12/3, p. 28.
[209] Finn 2012: 72.
[210] For the statistics and prosopography of Wakefield clinical clerks see Finn 2012: 178–87.

there. Twelve other men eventually became superintendents in other asylums in Britain, Ireland and the colonies. According to Finn's account Wakefield "graduates" constituted about 13% of the total medical personnel in English public asylums in the 1870s.[211] All the above suggests that the clerkships were a good preparation for asylum work and the experience at Wakefield gave the clerks advantages in obtaining positions in lunatic asylums afterwards.

In organising training at the Wakefield asylum Crichton-Browne took the best of two models of teaching represented by Laycock and Skae. His undergraduate courses were grounded in recent research and highlighted the importance of scientific methods and at the same time offered sufficient practical and clinical instruction appropriate for the students' level of knowledge. The clinical clerkships, as a form of photo-postgraduate training, built on the basic knowledge of insanity possessed by the qualified practitioners. This was a more challenging and hands-on type of learning without formal instruction but with supervised clinical and research work. Finally, Crichton-Browne added his own crucial ingredient into the asylum work and training — the laboratory-based research, which added further legitimacy to the Wakefield asylums' scientific enterprise. Since the clerkships did not grant specialised diplomas or degrees and the asylum doors were opened for medical researchers not exclusively employed in the treatment of insanity, the general medical community did not perceive Crichton-Browne's educational activities as promotion of specialisation.

Conclusion

In the period between 1859 and 1875 medico-psychological education followed the general trend of introducing more science into the curriculum. The newly established GMC was taking the medical training under control with a growing confidence. In the late 1860s it recommended a compulsory curriculum for all medical students and from the 1870s practical scientific training occupied an increasingly important role in medical the curriculum. Consequently, medical student and practitioners developed a self-image as "men of science" and viewed medicine as a scientifically based enterprise.

The medico-psychologists also sought to establish their branch of medicine as scientific. However, what constituted scientific medical psychology was highly contested. Most of the mid-Victorian alienists agreed on two general principles: first, that brain was the organ of mind and that mental diseases were diseases of the brain and, second, that heredity played an important role in mental health and disease. Based on these, the science of medical

[211] Finn 2012: 186.

psychology was connected to the physiology and pathology of the nervous system and, possibly, to one of the evolutionary theories. With limited common ground between various alienists there existed a great plurality of approaches. The lack of consensus was not uncommon in the British medical profession at the time. In most circumstances the MPA members accepted it and were contented to wait until further research and experience resolve the disagreements. However, the heterogeneity of medical psychology created significant difficulties for educators, who had to find a way to teach the foundations of the discipline systematically and without engaging with difficult controversies, at the same time making sure that the students received useful and applicable knowledge.

The debate which surrounded the courses on mental diseases taught by Thomas Laycock and David Skae in Edinburgh in the 1860s and early-1870s offered a useful insight into the existing pedagogical challenges. Although Laycock and Skae undeniably had very different ideas of what made medical psychology scientific, the core of the debate was concerned with pedagogy, not scientific practice. First of all, they differed on the content of the course with Skae putting greater emphasis on clinical experience in the wards and Laycock dedicating the larger part of his course to teaching the principles of scientific thinking and general physiological and psychological laws. Secondly, even though in reality the audiences at both courses were similar and included students with different aims and needs, Skae addressed his teaching to the future general practitioners, whereas Laycock envisioned his audience as future medical researchers. Thirdly, the two courses raised the question of who was better suited to teach students about mental diseases: a university professor of medicine (a generalist) or an experienced asylum superintendent (a specialist). This was a potentially inflammatory issue in the contemporary professional climate of resistance to medical specialisation. Finally, Laycock's and Skae's courses favoured different sites of instruction: university lecture rooms or asylum wards. The choice of the site was connected to the question of what type of graduates would serve the medical profession best: academically and scientifically proficient university men, who might lack practical experience, or practitioners who knew their way around an asylum ward and were familiar with the current practices but lacked research skills. Both models of instruction had important advantages and significant drawbacks, and neither one was unequivocally better than the other.

A more successful and elaborate programme of education was developed by James Crichton-Browne at the West Riding Lunatic Asylum in Wakefield the 1870s. He transformed the asylum under his superintendence into a robust research centre and a model therapeutic facility. The Wakefield asylum also hosted two training programmes: the undergraduate course

on mental disease in collaboration with the Leeds School of Medicine and the unpaid clinical clerkships for registered practitioners interested in advancing their knowledge about insanity. The material of the undergraduate course was grounded in the contemporary science and offered limited opportunities for clinical experience in the wards. Most of the instruction was theoretical and took place in the lecture room, however, Crichton-Browne illustrated theoretical principles with detailed cases, specimens and photographs. The clerkships, on the contrary, were entirely practice-based. There were no organised formal classes, and the clerks were expected to perform clinical duties in the asylums, keep detailed records, gather observations and participate in the asylum's scientific activities in the pathological and histological laboratories; and all of these under the supervision and direction of the more experienced medical officers. They also had an opportunity to publish the results of their research in the *West Riding Lunatic Asylum Medical Records* and present at the annual conversaziones. Even though the completion of the clerkship did not lead to an academic certificate or formal qualification, it was clearly recognised by other alienists and gave an advantage in the asylum labour market.

Between 1859 and 1876 the instruction on mental diseases remained voluntary and did not constitute a necessary part of medical training. The next chapter will explore how medical psychology fought its way into the compulsory medical curriculum.

Chapter 4. Compulsory Instruction: Developing Medico–Psychological Curriculum, 1876–1886

Introduction

"Among the mysteries which the most intelligent foreigner can hardly be expected to penetrate, is the maze of English diplomas, degrees, and licences in medicine," began an anonymous article in the *British Medical Journal*.[1] The author did not exaggerate the complexity and obscurity of the structures of medical training of his time — even contemporary medical practitioners did not agree amongst themselves on how the system worked and on the relative value of different degrees and certificates. However, unlike at the beginning of the nineteenth century, by 1876 a single set of requirements had been imposed by the GMC on all the licensing bodies. It included the length of training, minimum age for qualification and, most importantly, the national compulsory curriculum. Various licensing bodies and medical schools could introduce additional requirements or offer supplementary medical courses, but they had to follow the GMC-recommended curriculum if they were to keep their licence-granting power.[2] This chapter will focus on the lengthy and elaborate campaign of the MPA for inclusion of a course on mental diseases into the general medical curriculum.

In contrast with the previous chapter, here I will not deal with the fine points of pedagogy and the debates about the content of the courses, as they remained similar to those which took place in the previous decades. Instead, this chapter will address the structural changes in the British medical profession, the lunacy system and late-Victorian society, which impacted on the introduction of medico-psychological teaching into the compulsory medical instruction. In order to do it, I will engage in a detailed analysis of the interactions and conflicts between the various groups of stakeholders. Some of these groups consisted of medical practitioners — for example, the contemporary "medical establishment," including the GMC and the elite members of the medical corporations, or the "rank-and-file" of the medical profession, which consisted mostly of general practitioners and provincial doctors. The latter were represented by the British Medical Association (BMA, previously known as the PMSA) and expressed their collective voice through periodical publications such as the *BMJ* and the

[1] *BMJ*, 1 (1876): 541.
[2] Roberts 2009; Butler 1981, 1986.

Lancet. Another medical distinction was between the medico-psychologists, represented by the MPA and its journal, and the rest of the medical profession, particularly the majority which still resisted medical specialisation. Furthermore, on the question of education on mental disease these medical groups interacted with non-medical stakeholders: the lunacy commissioners, local and national government, and patient pressure groups. This analysis will not lead to a neat and orderly account but will help to reconstruct the confusion of entangled interests which surrounded the issue of including medical psychology into the compulsory curriculum and will illuminate the objectives of the relevant historical actors.

The MPA's campaign to add mental diseases to the list of compulsory subjects for medical qualification started in earnest in the mid-1870s and it took a decade to succeed. Although by the 1870s medical psychology had become a common elective subject at British medical schools, the GMC refused the petitions to officially include it into the curriculum until 1885.[3] There had been a number of strong arguments against it, some of which were related to the general overloading of the curriculum and fears of spreading specialisation, while others were concerned with the quality and quantity of medical knowledge about mental diseases. On the other hand, there were solid arguments for adding insanity to the compulsory curriculum, considering that all medical practitioners were expected to make informed judgements about a person's sanity with serious consequences: confinement in the asylum, early treatment with better prognosis, the freedom of individuals to conduct their own financial affairs and even the avoidance of the death penalty on the grounds of insanity.

The arguments of both sides were robust but not irrefutable and the disputes continued for a whole decade. In the end the success of the MPA's campaign was determined by several intra- and extra-professional political factors. The MPA achieved the support of major medical journals and of the BMA for their cause. Many celebrated alienists succeeded at developing their careers outside of the asylums and securing prestigious places amongst more elite professional bodies, such as medical faculties at British universities and the Royal Colleges, which helped them to promote a medico-psychological agenda within the licensing bodies. Those bodies, unlike the MPA, had representation with the GMC and, hence, the power to demand changes. Moreover, a respected member of the MPA, John Alfred Lush, served as a Salisbury MP from 1868 to 1880 and was appointed on an 1878–79 Select Committee to inquire into the state of medical education.[4] He used his position to raise the question of

[3] Oppenheim 1991: 25; Crammer 1996; Bynum 1991.
[4] *JMS,* 34 (1888): 471.

compulsory teaching and examination on mental diseases and secured the support of other committee members. During the same period several bills to amend the 1845 lunacy legislation were discussed in the Commons and further attracted the attention of the parliament to the issue of training doctors on insanity.[5] The MPA used all of the above to advance their campaign and put pressure on the GMC.

Moreover, the success of the campaign was aided by several contingent factors. For instance, by 1885 there occurred a generational change within the GMC and British medical elites. Many of the influential figures from the previous generation who were trained before the 1858 Act and shared severe anti-specialisation views, were replaced by younger more progressive colleagues. Another important factor was the rising attention of the press to the medical testimony in famous court cases. The emergence of the "New" Journalism with its focus on sensations and scandals heralded the urgent need to carefully maintain the image of the profession in popular media. Public disagreements between expert medical witnesses in notorious trials reflected poorly on the medical profession as a whole, especially when it was publicised in a sensationalised way by the newspapers. The early 1880s were rich in this sort of publicity and the most direct influence over the GMC's decision was the ridicule of medical witness testimonies during the Dublin Castle scandals. These highly publicised trials and the public scorn of the medical profession they caused impressed the representative of the University of Dublin on the GMC, Samuel Haughton, so powerfully that he changed his mind from vehement resistance to the compulsory teaching on insanity to strong support in 1885.[6]

In the first half of this chapter, I will describe the necessary historical context which surrounded the process of introducing a course on mental disease into the compulsory medical curriculum. Section 1 will focus on the state of British medical education between 1876 and 1886. It will demonstrate the various factors affecting and complicating the system of training medical practitioners and elucidate the conflicting interests of the main stakeholders in reforming British medicine. Section 2 will examine the state of medico-psychological practice at the time. I will argue that the alienists' position differed from that of other medical practitioners because their work was governed by two different sets of laws. First, as registered medical men, they were subject to control of the GMC and relevant medical legislation.

[5] K. Jones 1991b; Freeman 2010; Scull 1993: 334–74; Sposini 2021.
[6] On the history of insanity and Victorian trials see Smith 1981a, 1981b, 1988, 1989, 1991: Rollin 1996; Eigen 1995; 1999; 2010; 2016; Bartlett 2001; Hasson 2010; Carson 2018; Degerman 2019; Moran 2019. On the history of Garfield's assassination and the following trial see Millard 2011.

Secondly, the alienists were overseen by the Lunacy Commission, ruled by the Lunacy Law and, if they worked in a public asylum, governed by the local magistrates, who held the purse strings. This system of double management, the attempts to reform the Lunacy Law of 1845 and the growing demands of patient advocacy groups had important implications for the MPA's educational agenda.

The second half of the chapter is dedicated to the process by which mental disease became established as a part of the compulsory medical curriculum. Section 3 will describe the main events and aspects of the MPA's campaign, the various supporting forces the alienists managed to recruit and the reasons for the GMC's opposition. In Section 4 I will argue that the eventual success of the campaign was only in part determined by the unyielding efforts of the MPA and their supporters and that there were other historically contingent factors which tipped the scale towards agreeing to include medical psychology into the curriculum. To a large extent the GMC's decision depended on the desire to protect the public reputation of the medical profession threatened by unsympathetic press coverage.

1. The Challenges of Developing a Compulsory Medical Curriculum

The attempts to reform British medicine did not end with the passing of the 1858 Medical Act. As discussed in Chapter 2, the medical profession was not homogenous and comprised many groups with divergent interests. The 1858 Act constituted a compromise between the reformist goals of different factions, thus, none of them were completely satisfied with the outcome of the reform and the campaign for further changes continued.[7] Furthermore, during the following two decades, which passed since the act, the partisan memberships and agendas altered in accordance with the new developments in British medicine, such as, continued professionalisation, the increasing specialisation of research and practice and the growing ambitions of medical practitioners.[8] Nevertheless, improvement of medical education remained the cornerstone of all reform programmes as it was relevant to the majority of the pressing issues, be it the struggle against unlicensed practice, strengthening the authority of medical practitioners or reshaping the professional hierarchy.[9] In this section I will describe the state of the medical education in Britain between 1876 and 1886 and the educational agendas of different fractions of medical profession.

The 1858 Medical Act did not bring about a consistency of training on the national

[7] Roberts 2009; Peterson 1978: 30–39; Butler 1981: 62–68; Waddington 1984: 96–134.
[8] Roberts 2009; Butler 1981: 171–207.
[9] Loudon 1995; Butler 1981: 62–68.

level, as most general practitioners hoped. Although the GMC had been trying to improve and standardise medical education, the system remained confusing and convoluted with many redundancies and a lack of parity between license-granting and teaching institutions across the UK. By the 1876 the number of licensing bodies in the United Kingdom increased to nineteen:

1. Royal College of Physicians of London
2. Royal College of Surgeons of England
3. Society of Apothecaries, London
4. University of Oxford
5. University of Cambridge
6. University of London
7. University of Durham
8. Royal College of Physicians of Edinburgh
9. Royal College of Surgeons of Edinburgh
10. Faculty of Physicians and Surgeons of Glasgow (granted a diploma, not a degree)
11. University of Edinburgh
12. University of Glasgow
13. University of Aberdeen
14. University of St. Andrews
15. King and Queen's College of Physicians in Ireland
16. Royal College of Surgeons in Ireland
17. Apothecaries Hall of Ireland
18. University of Dublin
19. Queen's University in Ireland.[10]

As if the situation was not confusing enough, there also existed the so-called "conjoint schemes" — examinations which combined medicine and surgery held by two or more licensing bodies together. Moreover, the licensing bodies had different levels of examinations and qualifications: most corporations had hierarchies of memberships with different requirements (for example, members and licentiates of the Royal College of Physicians) and the universities granted medical diplomas in addition to medical degrees. Even though each institution boasted of the superiority of their certificates compared to all others, any one of them was sufficient to become an officially registered medical practitioner.

In the period between 1876 and 1886, students' educational success to a large extent

[10] *BMJ*, 2 (1876): 325–40; *Lancet*, 108 (1876): 353–68.

depended on how well they understood and could navigate the convoluted system of medical training. Professional periodicals, like the *BMJ* and the *Lancet* ran annual compilations of the requirements of the GMC and the licensing bodies. Special articles aimed at explaining the different ways to obtain medical qualifications also often appeared in press. For example, a piece in the *Lancet* titled "How to Obtain a Qualification" admitted that "confronted by so many licensing authorities, he [the student] may well be perplexed" and then explained how to acquire a medical license and suggested the best ways to arrange the studies and examinations for different purposes.[11] The author also evaluated the comparative merits of each portal of entry into the profession. According to him, for the majority of aspiring medical practitioners the best route to registration was through a combination of the Royal College of Surgeons' and the Royal College of Physicians' qualifications because "the course of studies required by these two bodies is fairly complete, and the examinations that have to be passed satisfactory, while by no means unduly severe".[12] However, the author admitted that a university degree was more prestigious and provided opportunities for deeper study. The University of London had "deservedly the highest rank" among the universities in the UK but the preliminary scientific examinations which had to be passed before students could enter the medical school were also the most difficult. The author warned that, unless the students were confident that they could pass these exams, it was "better not to attempt this task" and to choose a different path.[13] The article discussed other routes to obtaining a license in a similar fashion.

Irrespective of the medical writers' attempts to offer prospective students a concise and systematic explanation of British medical education, the only thing which was unarguably clear was that the system was "a dark chaos of qualifying diplomas" the relative value of which was under constant discussion.[14] It was such a mess of courses, institutions, interests and opinions that the two select committees appointed by parliament in 1878 and 1880 were unable to draw up any concrete recommendations for improving the system.[15] These committees were a part of continued efforts to reform medical education and practice through parliamentary legislation.

As with the 1858 Medical Act it took about twenty years and prolonged discussions to

---

[11] *Lancet*, 118 (1881): 448.
[12] Ibid.
[13] Ibid.
[14] *BMJ*, 1 (1876): 541.
[15] *Select Committee on Medical Act (1858) Amendment Bill Lords. Special Report, Minutes of Evidence, Appendix, Index,* House of Commons, Session 1878–79, 12: 1–534. Hereafter: *Select Committee on Medical Act 1878–79.*
Select Committee on Medical Act (1858) Amendment Bill. Special Report, Proceedings, Minutes of Evidence, Appendix, House of Commons, Session 1880, 9: 431–526. Hereafter: *Select Committee on Medical Act 1880.*

finally pass the Amendment to the Medical Act in 1886.[16] However, the deliberations of the 1870s and 1880s were significantly different from the ones which took place pre-1858.[17] First of all, most of the discussion happened within the medical profession with little input from laity. During this period, the bills to amend the Medical Act attracted very little discussion in parliament, especially in the House of Lords, members of which were very active in the previous medical reform debates. In fact, one of the major parliamentary impediments to amending the Medical Act in 1886 was that it consistently failed to secure enough political attention as it had to compete for it with the Irish Home Rule bills.[18] When it came to the content of the amendments, parliament mostly relied on the opinion of medical practitioners, which it solicited through the two select committees. The final bill was presented in the Commons by Sir Lyon Playfair (1786–1861), a scientist trusted and respected by the members of medical profession.[19] This demonstrated the growing regard of medical authority and increased self-regulation of the profession.[20]

Furthermore, the debates leading to the 1886 Amendment to the Medical Act also highlighted the differences of opinion and competing interests within British medicine and shed the light on how deeply divided the medical community was at the time. Three groups with divergent interests which had the most impact on the medical education were: the GMC, the non-university licensing bodies and the university medical schools which could grant medical degrees. Although the members within each group were by no means homogenous, they shared some key approaches to education and faced similar challenges. Let us examine each group in turn.

1) The General Medical Council

One of the main functions of the GMC was overseeing medical education across the United Kingdom. Since the establishment of the Council, all its members, including the Crown appointees, had been medically trained men.[21] This, again, signified the government's assumption that the issues of ensuring the quality of medical education should best be left to the members of the profession to resolve.[22] The Council was envisioned as a body which would

[16] 49 & 50 Vict. C. 48.
[17] Roberts 2009.
[18] Ibid: 52.
[19] *DNB.*
[20] Roberts 2009; Waddington 1984: 176–205.
[21] Roberts 2009: 50.
[22] Roberts 2009: 53–54; Waddington 1984: 176–205.

represent all the interests of British and Irish practitioners but in practice the composition of its membership and its place within the national government meant that it mainly served to advance two specific kinds of interests related to the national health and the established medical elites.[23]

The GMC was not just expected to ensure that licensed medical practitioners possessed good knowledge and skills to perform their professional duties, but also that there were enough qualified practitioners to fulfil the needs of the growing civilian population and British army and navy.[24] In 1876 the GMC president, regius professor of medicine at Oxford, Henry Wentworth Acland (1815–1900) shared with the Council a part of a letter he received from William Farr (1807–1883), epidemiologist and statistician, in relation to a recent report of the General Register Office. Farr wrote: "One thing is certain, that the medical attendance for the people of England was extremely defective in 1851, and that it is more defective in 1876."[25] By this he meant that the proportion of medical practitioners to the UK population was steadily declining. It went from 9.7 practitioners per 10 000 of population in 1851 to 7.8 in 1871. He also pointed to the fact that the high demands for competent medical staff in the army and navy had been hard to meet. Farr warned Acland and, through him the GMC, that if this trend continued medical care would become inaccessible to a large portion of the UK population. In his letter Farr also offered an explanation of what caused the situation: "We know how this arises. Everyone in the profession wishes to see every man in it instructed to the highest standard."[26]

Farr's conclusion points to a conflict between the national interests and the interests of the medical profession. The latter strove to gain more respect and recognition for medical practitioners, to increase their authority and incomes. Establishing high educational standards was an important part of that struggle, as it helped to present the medical professional as a brilliant gentleman-scientist.[27] However, the main national interest was to supply the population with sufficient competent medical attendance. Hence, the government expected the GMC to work towards achieving that goal rather than pursue the interests of the medical profession. In the words of the Council's president, they had to find an answer to the question "how to insure such a test of a sound minimum education in each branch of the kingdom as can be relied upon not so much for its severity as for its wisdom, and which we may feel sure is the

[23] Roberts 2009: 51–52; Butler 1981: 65.
[24] Haynes 2017: 9–35.
[25] *BMJ,* 1 (1876): 668.
[26] Ibid.
[27] Roberts 2009: 54–55; Digby 1994: 135–69; Bynum 1994: 118.

fittest preparation for actual practice and daily life."[28]

This approach to ensuring the quality of education also suited the medical elites, whose representatives sat on the Council. Since the GMC concerned itself with the minimum requirements but did not dictate any standards beyond them, the licensing bodies were free to add to it as they saw fit.[29] They could also uphold a hierarchy of the examinations for different qualifications which required different levels of knowledge and education, which supported the professional hierarchy.[30] Even though both a qualification granted by the London Royal Colleges and a university medical degree were enough to secure a place on the Medical Register, it was widely known that a degree was more prestigious. In the same way, being a full fellow of the Royal College of Physicians signalled to colleagues and patients that the practitioner was more experienced and knowledgeable than an ordinary member of the Royal College of Surgeons.

The perpetuation of inequality within the profession even after the creation of a single national register was, of course, beneficial for the medical elites, as it maintained their privileged position. Although the rank-and-file general practitioners, represented by the British Medical Association and publications like the *Lancet*, continued to campaign for the "single portal" of entry into the profession, it was unlikely that the GMC would agree to it. The majority of the Council members (17 out of 24) represented a specific licensing body and the other seven were respected members of medical profession who also inevitably belonged to at least one of the licensing bodies.[31] They would not vote for stripping their institution of the medical license-granting power, nor would they impose a strict single-standard professional examination and take away the licensing bodies' rights to tailoring their curricula to fit their views on medical education and corporate interests. However, the GMC's approach of instituting the minimal necessary requirements for registration helped to make sure that the licensing bodies could not sacrifice the standard of their examinations to make them easier and, therefore, attract more fee-paying students, as was the case before the 1858 Medical Act.[32]

At the annual meeting of the GMC in 1876, the members formulated their role and sphere of influence with regard to education in the following way:

> It may be quite right that time, money, and energy should be freely, nay lavishly, expended by

[28] *BMJ,* 1 (1876), 668. On the GMC's goal to ensure safe practice see Newman 1957: 194–264; Butler 1981; Bonner 1995: 251–71.
[29] Butler 1981: 62–68.
[30] Kelly 2017: 17–42; Digby 1994: 11–38.
[31] Roberts 2009.
[32] Butler 1981: 64.

> great investigators, on matters which may be useless, even injurious, to ordinary students. But it cannot be doubted that great freedom of action in this matter should be left to individual teachers of advanced students, while the Council collectively fixes the standard which is considered by it indispensable for attaining an adequate knowledge and skill for the practice of the profession.[33]

2) Non-University Licensing Bodies

The non-university licensing bodies were the institutions empowered by the GMC to examine candidates for medical qualifications which did not offer a programme of study or training. The Royal Colleges in London, Edinburgh and Dublin belonged to that category, as did the Society of Apothecaries and the Apothecaries Hall of Ireland. Although they sometimes offered courses or lectures, the applicants for licenses had to obtain most of their necessary instruction elsewhere and were not obligated to take any of the classes offered by the examining licensing body. This path to entering the medical profession relied on the numerous medical schools and teaching hospitals which could not grant degrees and specialised in preparing students for examinations for medical qualifications.

In his testimony to the Select Committee in 1878, the GMC President Henry Acland claimed that the British medical education system functioned in the following way: "the instrument in the hands of the council [GMC] is the examination system, and the examination system guides studies."[34] The licensing bodies incorporated the GMC recommendations into their examination programmes and published them to inform the students of the requirements for specific qualifications. It was then the students' responsibility to find ways to fulfil these requirements. Luckily for the students, there was a large number of medical schools and teaching hospitals which could not grant registrable degrees or certificates. For a fee they offered to prepare students for their exams in accordance with the latest licensing conditions such as attending specific courses and completing a period of clinical practice.[35] Hence, to attract the students the schools compiled their curricula based on the licensing criteria and had to make sure that popular licensing bodies, for example the Royal College of Surgeons, approved the training provided by the schools as sufficient for qualification.

The role of examination in medical education described by Acland had two important consequences. First, the students were considered to have significant control over their own training and were expected to be enterprising and strategic in obtaining medical knowledge. It

---

[33] *BMJ*, 1 (1876), 670.
[34] *Select Committee on Medical Act 1878–79:* 30.
[35] Butler 1981: 79–83, 119–70; 1986.

was not necessarily the responsibility of a medical school to offer all the needed facilities for learning but the students' responsibility to find ways to prepare themselves for the examination. Acland offered the following example of how the system was expected to function:

> For instance, at Oxford, we have been always for years past in the habit […] of putting written questions on subjects which we have every reason to believe that the students have not studied; and why? Because all the examination papers were public, and then future students knew that they were likely to be examined in those subjects. In that way we gradually have pushed on the study of particular departments by drawing their attention to those papers, as embodying subjects which they might be examined in.[36]

Although this example features a university, the success of the students qualifying through a non-university licensing body was even more reliant on their initiative since there was no course of study offered there at all. This approach meant that the GMC did not have to interfere directly with *teaching* at medical schools and there were no official consequences for deficient instruction, only for sub-standard examinations.

The second consequence follows from the first. Even though it seemed like the GMC and licensing bodies did not control pedagogical practices or dictate the subjects the students could learn beyond the minimum requirements, in practice, to a large extent the examinations determined the medical curriculum. The medical schools which did not grant degrees attracted their main paying audience by offering instruction tailored to the qualification requirements.[37] They could offer extra subjects and more advanced courses, but most students would not take them to save money and energy for compulsory subjects. Moreover, since the medical schools depended on the students' fees to cover the running costs and the teachers' salaries, they could not afford to run courses which did not recruit enough paying students.[38] The universities could impose additional subjects on the students reading for a medical degree, but if the curriculum was too difficult or time-consuming compared to other institutions, the students would also choose other portals of entry into the profession. Hence, the majority of medical teachers had relatively little power to shape future medical practitioners because they could not influence the examination requirements.

---

[36] *Select Committee on Medical Act 1878–79:* 30.
[37] Butler 1986; Bonner 1995: 268–69; Kelly 2017: 17–42, 104–36.
[38] Butler 1981: 79–83, 119–70.

3) Universities

The final group of medical practitioners who had significant influence over medical education was the academic staff of university medical schools. By the 1880s it was widely accepted that a medical degree was superior to a medical certificate granted by a non-university licensing body, although both led to medical registration.[39] The main difference between the certificates and degrees was the level of training and examination in preliminary scientific subjects.[40] University matriculation exams made sure that the students possessed a sufficient level of preliminary knowledge and were capable of following advanced scientific instruction.[41] The universities could also afford to outfit laboratories for practical courses in science, unlike smaller non-university medical schools which prepared students for licensing exams.[42]

However, the old English universities of Cambridge and Oxford remained inaccessible for most people embarking on a medical career because of the cost of tuition, the requirement to first complete a preliminary undergraduate degree at the same university and, finally, the necessity of residence at the university for several years.[43] The Scottish universities, although more welcoming to students from lower socio-economic backgrounds, could not meet the growing demand for university medical education and accommodate all of the British aspirants to a medical degree.[44]

Hence, new universities began to emerge in the United Kingdom in the nineteenth century. The first of them was the University of London, the opening of which in 1828 was briefly discussed in Chapter 2 of this thesis. By the 1870s it became a large and successful enterprise and included two colleges: UCL and King's.[45] Both offered medical training. A London medical degree was highly regarded by the medical community however, there were some significant problems. First of all, the preliminary scientific examination necessary to enter medical studies at the University of London was notoriously hard. Combined with a difficult matriculation it meant that few applicants would reach the level of professional studies. Based on the figures provided in Stella Butler's work, between 1871 and 1890 only

[39] Butler 1981: 119–207; 1986; Bonner 1995: 251–79; Digby 1994: 11–38; Whyte 2015. For examples of primary sources see *Lancet,* 118 (1881): 448–50; *BMJ,* 1 (1885): 857–64.
[40] Butler 1981: 172.
[41] Anderson 1992: 4–22.
[42] Butler 1986; Bonner 1995: 251–71.
[43] Butler 1981: 86–98; Weatherall 2000: 210–53; Anderson 1992; Engel 1983.
[44] Butler 1981: 99–118; Anderson 1992.
[45] Butler 1981: 68–78; Whyte 2015: 51–66.

55% of students successfully matriculated and only 52.2% of that cohort passed the preliminary scientific exams, meaning that only 29% of all who attempted matriculation managed to reach the level of professional medical education.[46] This led to what was called "the medical grievance" — the discontent of students and metropolitan medical practitioners with the difficulty of examinations.[47]

The BMA was so concerned with this grievance, that its Metropolitan Counties Branch commissioned a special report on the situation with medical degrees at the University of London and held a special meeting to discuss it.[48] All who attended agreed that the preliminary examinations were too difficult for the students' level of study and that it disadvantaged metropolitan students compared to their Scottish and continental counterparts. For example, one of the BMA members, physician John Syer Bristowe (1827–1895) claimed that "many men who become most able practitioners and ornaments to their profession, are, […], quite unable to pass that examination."[49] According to him, it was unfair and counterproductive to ask boys who still had very little training to pass such an examination. Even the best results would be achieved by cramming rather than intelligent study.

When approached with these concerns, the University's Registrar stated that the goal of their educational approach was not "to educate a large number of medical practitioners above what they would have been educated without the University, but to educate a small number of practitioners highly."[50] Notably this goal went against the GMC programme of setting the minimal standards for safe practice and was precisely what Farr cautioned against in 1876. The examinations standards were deliberately set high to ensure that only the best students could pass them and went on to become exceptionally good practitioners. Also, a relatively low number of graduates per year, compared to Scottish Universities, helped to maintain the high value and authority of the London degree. Those who managed to obtain it were seen as truly "scientific" practitioners.[51]

Furthermore, the university senate blamed the low numbers of students successfully passing the preliminary exams on their teachers. This brings us to the second serious problem of the University of London — the separation between the teaching and examining staff. The university's rules prohibited any direct involvement of the college teachers in the examinations.

---

[46] Butler 1981: 175.
[47] Ibid: 173–86.
[48] *BMJ*, 1 (1885): 557–64.
[49] Ibid: 559.
[50] Ibid: 559.
[51] Butler 1981: 176.

The Senate formed special committees to compile syllabi for examinations, draw up examination criteria and appoint appropriate examiners[52]. These committees took very little notice of the teachers' opinions on what and how should be taught. As a result, the colleges' teaching staff were precluded from developing new courses or updating the existing ones with new material. They found themselves in a situation similar to the non-university medical schools: their pedagogical purpose reduced to preparing students for exams set by external committees. Since UCL and King's College did not possess the charter to grant their own medical degrees or registrable certificates, they did not have direct representation in the GMC and could not advocate for their interests directly.[53] The University of London's seat on the GMC was usually taken by one of the Senators who were unsympathetic to the grievances of the teaching staff. The colleges, the community of the university's graduates and the BMA all were campaigning for the reform of London medical education outside the GMC meetings, but the changes were slow to appear.[54]

The situation in London was especially urgent because in the 1870s and 1880s medical schools in the English provinces started merging with the local colleges and offering stronger scientific training in addition to purely medical studies.[55] This process of amalgamation played an important role in the establishment of new "redbrick" universities.[56] The most notable step in this development was the establishment of the Victoria University in the north of England in the late 1870s.[57] It was founded in Manchester, after the local Owen's College amalgamated with the medical school and was granted the royal charter. At first it was not allowed to grant medical degrees, but in 1882, on the recommendation of the second parliamentary select committee, permission was granted, and the university's structure was changed to federal, which allowed other northern medical schools to join and obtain the opportunity to grant medical degrees. In its final form the Victoria University spread across four cities: Manchester, Leeds, Liverpool and Sheffield. As a chartered institution the Victoria University gained a seat on the GMC and with it an opportunity to influence decision making on the issues of medical education and curriculum.[58] Unlike the University of London, the new institution employed the same people as teachers and examiners which gave it more freedom in creating a more

[52] Butler 1981: 177; Merrington 1976.
[53] Butler 1981: 177–87.
[54] Ibid.
[55] Butler 1981: 119–70; 1986; Bynum 1994: 92–118; Bonner 1995: 259–64; Gooday 1991a.
[56] Butler 1986; Whyte 2015.
[57] For the history of the Victoria University and its medical schools see, for example, Butler 1981: 119–70; 1986; Whyte 2015: 101–18.
[58] Butler 1981: 134.

innovative curriculum.[59]

The tensions surrounding the medical grievance in London ran so hight that in the late 1880s UCL members seriously considered affiliating their college with the Victoria University.[60] Although this did not happen and in later years the University of London was significantly reformed, the geographical distribution of medical students across Britain changed with the new provincial universities attracting more and more students who in previous decades would have gone to London or Edinburgh.[61]

The task of reforming and enforcing the compulsory medical curriculum was an extremely difficult one. On the one hand, the GMC had to look for compromises between the conflicting interests of the state, non-university licensing bodies and university medical schools. On the other hand, large segments of the medical profession, such as teachers at the non-licensing medical schools, medical associations and medical students, had no direct representation in the GMC: thus, they had to make their interests known through widely publicised campaigns. The MPA campaign to introduce medical diseases into the curriculum took place within this confusing and volatile context.

2. The Precarious Position of Asylum Practitioners

The campaign to make the study of insanity compulsory for all medical students was taking place against the backdrop of the contemporary state of medical psychology and the asylum system at the time. As in the earlier parts of the nineteenth century, the establishment of medico-psychological education played an important role in the MPA's efforts to advance the interests of British alienists and increase their medical and scientific authority. In this section I will briefly outline this wider context of medico-psychological practice between 1876 and 1886 focusing on the features which distinguished it from general medicine and other budding medical specialisms.

The most crucial difference between asylum practice and other kinds of medical practice was that it was governed by two separate sets of laws. Asylum doctors, like all medical practitioners, were governed by the GMC and the 1858 Medical Act. Since the Act stated that all state-supported medical posts must be filled only by registered medical practitioners and the membership of the MPA required medical qualification, all British alienists were medically

[59] Ibid.
[60] Butler 1981: 139–40.
[61] Butler 1981: 191–96; Whyte 2015: 69–120.

trained in accordance with contemporary standards.[62] Additionally, the asylum practice was regulated by the lunacy legislation and overseen by the Lunacy Commission. The latter consisted of five laymen, including the chairman, three medical practitioners and three lawyers, which challenged the supremacy of medical authority in the asylum system and gave significant control over medical practice in lunatic asylums to laymen.[63] This must have been especially grating when compared to the growing self-regulation of the rest of British medicine.

Furthermore, working with the insane was burdened by additional legal complications. In the case of mental disease diagnosis was not just a medical act but also a legal one with far-reaching consequences for the patient and, possibly, the medical practitioner. The decision to confine the insane person at an asylum, which normally followed the diagnosis, stripped them of most of their political and economic rights. Hence, the certification of a person as insane was unlike any other medical procedure: it involved special paperwork, witnesses and legal liability.[64] The public fear of wrongful confinement had not subsided by the 1870s and was fed by highly publicised court cases against alienists and general practitioners, who signed the certificates of insanity. Such cases did not only damage the alienists' reputation but also caused fear and resistance to certification of insanity amongst the general practitioners.

Another distinguishing feature of asylum practice was its entanglement with the public bureaucracy which led to important structural and financial consequences. First, the organisation of the lunacy system which dictated that mental patients had to be treated in special institutions, imposed a degree of specialisation on alienists. Specialised hospitals played an important role in the development of medical specialisation in the United Kingdom and abroad.[65] As could be expected, in Britain with its animosity to specialisation, such hospitals attracted severe criticisms and were accused of damaging the general hospitals and threatening clinical instruction of medical students.[66] However, the specialist hospitals for the insane were established by the government as a part of the public bureaucracy and their status was enforced by the lunacy legislation. The lunatic asylums in general did not attract much criticism as specialist hospitals and the medical community mostly seemed to treat them as a necessity. Resident medical officers in public asylums were prohibited from private practice while they occupied their positions, therefore their practice was restricted to only mental

[62] Medical Act 1858, 21 & 22 Vict., c. 90; *JMS*, 11 (1865): 396.
[63] K. Jones 1991b: 92. For a detailed discussion of the politics of lunacy system see Ellis 2020; Forsythe et al. 1999; Melling and Forsythe 2006.
[64] Wright 1998.
[65] Weisz 2003; 2006.
[66] Weisz 2003: 567–72; 2006: 29–34.

patients and only institutional care — precisely the definition of specialist which was rejected by British medical practitioners in other areas of their profession.[67]

Public lunatic asylums, which provided the majority of jobs for alienists in the 1870s and 1880s, were not just specialist hospitals but also rate-supported institutions. The money raised by taxes, which financed county asylums, came with strings attached. Local magistrates, the Poor Law authorities and boards of lay governors interfered with the running of asylums and often influenced treatment of the patients for non-medical reasons, most of which were dictated by the desire to cut expenditure.[68] Under the pressure to economise the asylum buildings became more crowded, the patients' diets poorer, and the proportion of medical officers and attendants to patients decreased steadily.[69] Even when the asylum superintendents succeeded at bringing down the costs of maintaining their establishments, they still remained "extravagantly expensive" compared to other Victorian rate-supported institutions, like workhouses and prisons.[70] Defenders of the asylums claimed that the higher costs were justified because the aim of the lunatic institutions was to cure insanity and not just to warehouse the insane. Unfortunately, the rates of cures in British asylums did not support this claim: in 1869-1888 the national average rate of recovery remained at approximately 40%.[71] Once admitted over a half of the patients stayed at an asylum indefinitely. By 1875 the number of people confined in institutions for pauper lunatics reached 56 403 and continued to grow; each asylum housed hundreds of patients.[72] With the growth of asylums grew the pressure to save funds or show better results.

For the medical officers of private asylums, the situation was not much better. Although they did not have to struggle with constant demands to cut costs and accusations of running their institutions inefficiently, they had to fend off the mistrust of the public. The proprietors of private asylums were often portrayed in the press as greedy and dishonest business owners who were driven by profit rather than benevolence and compassion befitting men of medicine.[73] Their work too closely approached the ungentlemanly world of trade and raised uncomfortable memories of the abuses at the madhouses of the eighteenth and early nineteenth century.[74] Since the private asylum doctors were seen to benefit financially from every patient

[67] Weisz 2006: 43.
[68] Scull 1993: 310–15; Bartlett 1999; Forsythe at al. 1999; Ellis 2006, 2008, 2020; Farquharson 2016.
[69] Scull 1993: 310–15.
[70] Ibid.
[71] Ellis 2008: 293.
[72] Scull 1993: 362.
[73] McCandless 1981; Owen 1989: 139–201; Schwieso 1996; Scull et al. 1996: 76–78; Lush 1879.
[74] McCandless 1981: 339–40.

confined to their institution, they were not trusted to diagnose mental disease or sign certificates of insanity lest they would be tempted to supplement their earnings by wrongfully imprisoning sane people.[75] This led to a seemingly counterintuitive situation when a portion of people who had the most knowledge and experience of working with the insane could not officially certify lunatics but medical practitioners who had no special training or experience of working with mental patients were legally allowed to sign the certificates of insanity.[76] This was part of a larger difficulty for medical psychologists: in general they were not awarded the same degree of public trust as their colleagues in other areas of medicine.[77] However, the proprietors of private asylums attracted more opprobrium, often even from their colleagues who worked in the public asylums. Also, the private asylum officers were sued for wrongful confinement more often than their colleagues in public institutions.[78] Most likely the reason for this was not their exceptional dishonesty but that their clientele was wealthier and had the means to sue. In middle- and upper-class families there were also stronger motives for dishonest family members to conspire to send their relatives to a lunatic asylum.[79]

The dissatisfaction with the asylums' inefficiency and the public mistrust found expression in popular sensational journalism and patient rights activism. The public concerns about wrongful confinement were so strong that the House of Commons appointed a Select Committee "to inquire into the operation of the Lunacy Law, so far as it regards the security afforded by it against violations of personal liberty."[80] Press coverage of the committee proceedings and of notorious court cases, such as Louisa Lowe's and Georgina Weldon's, in press proved to be popular and led some enterprising journalists to conduct their own investigations for scathing exposés. For example, a serialised story appeared in the *Pall Mall Gazette* in 1884.[81] The author under a humorous pseudonym "Amateur Maniac" wrote a story about arranging to be confined to a private asylum. Although highly entertaining (just the pretend madman's claim that he had recently "given up an appointment as a walrus at the Zoological-gardens […] through a slight misunderstanding with a female exhibit" must have elicited a chuckle from the readers), the story exposed the worrying ease with which a person could be certified as insane and imprisoned at a private asylum by determined relatives or

[75] Scull et al. 1996: 76–78; K. Jones 1991b: 93–95; Renvoize 1991: 65–67; Owen 1989: 139–201.
[76] Wright 1998; Lush 1879.
[77] Renvoize 1991; Turner 1991: 3–16; Scull 1993: 232–66; McCandless 1981: 343–44.
[78] Scull et al. 1996: 75–78; McCandless 1981.
[79] Owen 1989: 193–201; McCandless 1981; Schwieso 1996; Brückner 2021.
[80] *Select Committee to inquire into Operations of Lunacy Law, as regards Security against Violations of Personal Liberty. Report, Proceedings, Minutes of Evidence, Appendix, Index,* House of Commons, Session 1877, 13: 1. Hereafter: *Select Committee on Lunacy Law 1877.*
[81] *Pall Mall Gazette,* 27 August 1884, pp. 1–2; 30 August 1884, pp. 1–2; 2 September pp. 1–2.

"friends".[82] Once in the asylum the journalist started behaving normally and tried to convince the staff of his sanity but did not succeed. In the end, his friend, who played the role of the Amateur Maniac's relative during the admission procedure, had to come and release him. The journalist described his words and behaviour and quoted how they were misrepresented in the certificate of insanity, to demonstrate how unscrupulous or incompetent practitioners could distort the situation. The story became very popular and quickly spread to other newspapers across the UK.[83]

Former mental patients, their relatives and friends also took an active part in criticising the asylum system and campaigning for reform. They wrote to newspapers and published their own pamphlets describing the injustice of the current system. The activists organised themselves into the Alleged Lunatic's Friend Society in 1845, which was succeeded by the Lunacy Law Reform Association in 1873.[84] Louisa Lowe (1820–1901), who was confined to a private asylum by her husband and spent 18 months trying to free herself, joined the cause right after her release in April 1872. She became the head of the Lunacy Law Reform Association, wrote pamphlets and articles for periodicals, gave testimony to the Select Committee in 1877 and presented twice at the congresses of the Social Science Association.[85] Lowe was particularly concerned about the fate of women who, like her, could be imprisoned in private asylums by their husbands as a way to get rid of an inconvenient wife without scandal. In the case of wrongful confinement, the situation of women was especially dire until the 1882 Married Women's Property Act which, amongst other things, granted married women the right to sue the medical men who detained them and even their own husbands, if they so chose.[86] It was too late for Mrs Lowe but Georgina Weldon, another famous victim of a scheming spouse, availed herself of this opportunity with resounding success.

Mrs Weldon was more fortunate than Mrs Lowe and managed to avoid imprisonment in a mental institution. She suspected that her husband was planning to send her to an asylum and, when in 1878, the carriage with asylum attendants arrived at her door, she managed to send for Mrs Lowe, who came to her rescue.[87] Georgina Weldon (1837–1914) was a well-connected, wealthy socialite and she used her position and fame to raise publicity around her

[82] *Pall Mall Gazette,* 27 August 1884, p. 1.
[83] For example, *Dundee Advertiser,* 28 August 1884, p. 5; *Belfast News-Letter*, 1 September 1884, p. 8; *Manchester Evening News*, 3 September 1884, p. 2; *Daily Gazette for Middlesbrough*, 6 September 1884, p. 2.
[84] McCandless 1981: 342.
[85] Owen 1989: 168–201; Brückner 2021.
[86] Owen 1989: 200–01; Brückner 2021; Schwieso 1996.
[87] Owen 19899: 160–63.

own case and to advocate for the cause of the Lunacy Law Reform Association.[88] When the 1882 Act passed she decided to sue her husband and his medical allies but in her own extravagant fashion. She set up an office, taught herself jurisprudence and represented herself in court during the cases she brought against all of the conspirators between 1883 and 1888.[89] Weldon was a magnet for the attention of the British press and her advocacy significantly damaged the image of alienists and the private institutions for the insane.

The medical press also paid much attention to the lunatic asylums and problematic aspects of medico-psychological practice. The *Lancet* commissioned its own investigation into the state of the lunacy system.[90] The *Lancet* reports contained critical notes on the practices of the asylums they visited and questioned the need for asylum treatment for all mental patients, suggesting that some could receive sufficient care in the special wards of workhouses, some could be boarded out and some stay with their families.[91] However, the overall judgement was positive, and the necessity of asylums was upheld. On the issue of certification of insanity, the *Lancet* commissioners suggested that mental patients should be admitted into the asylum in the same way that other patients were admitted to general hospitals without undergoing a stigmatising legal procedure. The *BMJ* also published a series of papers on lunacy reform which condemned private asylums and the use of laws intended for obvious madmen to confine people unnecessarily and even cruelly.[92]

In the 1870s and 1890s British alienists practiced under constant scrutiny from the Lunacy Commission, national and municipal governments, activists for patients' rights, and professional and popular press. The usefulness of the asylums was called into question, as were the good character and competence of asylum practitioners. The MPA had to find ways to improve the social standing of the alienists, to advocate for the reforms which would lead to increased self-regulation of asylum practice and to protect the reputation of medico-psychologists. The campaign to include a course on mental diseases into the medical curriculum was one of the ways to address those issues.

[88] *DNB;* Jones 1991b: 94; Brückner 2021.
[89] Owen 1989: 164–67.
[90] Granville 1877.
[91] Ibid.
[92] *BMJ,* 2 (1878): 671, 682; 1 (1879): 24–25, 128–29.

3. The MPA's Campaign to Include Mental Disease into the Curriculum

The idea of making instruction on insanity compulsory for all medical students had its supporters amongst British alienists from the beginning of the nineteenth century and by the 1870s this support grew into an organised campaign to add a course on mental diseases to the list of subjects recommended by the GMC. Although the campaign quickly gained approval from the majority of MPA members and many rank-and-file medical practitioners beyond the circle of alienists, it still took ten years for it to achieve its goal. In this section I delineate the major stages of the campaign, outline the main reasons offered in support of including insanity into the standard curriculum and demonstrate that the obstacles the campaigners had to overcome were in part characteristic of to the general state of British medicine and in part related to specific issues of medical psychology.

The campaign started with a petition to the licensing bodies signed by the lecturers on insanity from across the UK. The document asked the examining boards to accept a three-months clinical study course at an asylum as a substitute for a course of the same duration at a general hospital.[93] The purpose of it was to provide an incentive to medical students interested in insanity to engage in a deeper study of the subject while they were preparing for medical qualification.[94] The teachers claimed that while the instruction on insanity remained an extra-curricular course, very few students would chose to attend. They thought that the medical curriculum was already tightly packed with necessary courses, and that it did not leave the students enough time, energy and money to explore additional subjects.[95] Hence, being able to take clinical training in insanity as part of a qualification programme would make it more popular with the students and attract more young medical practitioners to research and treatment of mental disease.[96]

The initiator of this petition was Thomas Clouston (1840–1915), a well-known Scottish alienist, editor of the *Journal of Medical Science* and a popular teacher.[97] He trained under both David Skae and Thomas Laycock and succeeded both of them: as a superintendent of the Morningside Asylum and as a lecturer on mental disease at the University of Edinburgh.[98] In 1875 Clouston proposed the petition at the MPA's annual meeting to secure the Association's

[93] *JMS*, 21 (1875): 458–60; Eames 1885: 322–23.
[94] *JMS*, 21 (1875): 458–60.
[95] Ibid.
[96] *JMS*, 21 (1875): 452–67; Duncan 1875: 319; Eames 1885: 323.
[97] Beveridge 1991. Unfortunately, the names of his co-signatories are not known as the only copies of the petition which survived to this day did not have the signatures, only the text of the petition.
[98] Beveridge 1991; 1995a.

support for his initiative. It was greeted with enthusiasm. The only criticism recorded in the minutes was that its demands were rather mild: some members suggested that they should propose compulsory clinical instruction at an asylum for all medical students.[99] Answering these comments Clouston revealed the rest of his strategy:

> I think it is better to say nothing about making the attendance compulsory at present. Let us first endeavour to get in the thin edge of the wedge. When we succeed in doing that we may then try to drive it in a little further.[100]

Indeed, over the following ten years the alienists relentlessly worked on wedging their subject into the busy medical curriculum. Having started with petitioning the licensing bodies, Clouston and his co-signatories managed to gain some support amongst their members, most notable the University of London and the Royal College of Physicians. A large proportion of the BMA and influential medical periodicals, like the *BMJ* and the *Lancet,* joined the MPA's educational cause.

Then, at the meeting in July 1879 the MPA made the decision to advance the campaign further and to petition the GMC to make an examination on mental diseases compulsory for all British medical degrees and licences. Thomas Clouston, who proposed the motion, emphasised that it was a good time to bring this subject up because a Select Committee was at the time conducting an investigation into medical education and the "subject of mental disease had attracted the attention of many members of the Medical Council as being the subject with which every medical man should be well acquainted".[101] The discussion of medico-psychological training during the Select Committee investigation was not a coincidence but the deliberate action of another MPA member, John Alfred Lush (1815–1888), who was a proprietor of a private asylum and was a Salisbury MP from 1868 to 1880. Lush was a member of the 1878–1879 Select Committee and raised the question about teaching and examining on mental diseases.[102] John Charles Bucknill, the author of the first and most influential textbook on insanity to that date, seconded Clouston's motion adding that "he had done what he could at the Royal College of Physicians of London to get mental disease recognised as a subject for a license, as it is for a membership" but the establishment of the conjoint examination board between the Royal College of Physicians and the Royal College of Surgeons stalled his

[99] *JMS*, 21 (1875) 459.
[100] Ibid: 460.
[101] *JMS*, 25 (1879): 439.
[102] *Select Committee on Medical Act 1878–79*: 20, 37.

attempts.[103]

Following the MPA meeting a communication was sent to the GMC in August 1879:

> Gentlemen, – At the Annual General Meeting of the Medico-Psychological Association held on July 30, 1879, under the presidency of Dr. Lush, M.P., the following resolution was passed unanimously: "That this Association petition the General medical Council to have Mental Diseases made a subject of examination for all degrees and licenses to practice medicine in the United Kingdom." I beg to submit this resolution to the General Medical Council as the petition of the Medico-Psychological Association, and to express the hope that the Council will give their favourable consideration thereto.[104]

In the debates surrounding the topic of compulsory education on insanity, the supporters of the campaign put forward several central arguments. First of all, the lunacy law at the time enabled all licensed medical practitioners to sign certificates of insanity, regardless of how much training or experience they had on the subject.[105] Since mental patients were not admitted to general hospitals, many medical students would not encounter any mental cases at all during their studies, even if some teaching on mental disease was incorporated into lectures on clinical medicine.[106] Yet, having qualified they would be expected to accurately diagnose insanity and, by doing so, make decisions which drastically changed the patients' lives. If a doctor made a mistake and certified a sane person as insane, it would lead to confinement in an asylum and stigma as "a lunatic, which would stick for the rest of [their] life, and if [they] have any children, especially daughters, will certainly injure their prospects".[107] Medical men who had not encountered many insane patients could also fall prey to scheming relatives or "friends" of the "patient" and, just like in the Amateur Maniac's exposé in the *Pall Mall Gazette*, be manipulated into detaining a sane person in a mental institution.[108] However, if a general practitioner did not recognise the early signs of insanity in his patient or hesitated to take action straight away, it would cause equally severe consequences, as the window of opportunity for successful early treatment would be lost and the patient might end up in an asylum for a long time, if not their whole life.[109]

Secondly, general practitioners were often called as medical witnesses in court cases.

---

[103] *JMS*, 25 (1879): 439.
[104] *GMC Minutes,* 1879: 371.
[105] Wright 1998.
[106] *BMJ*, 1 (1879): 668–69; White 1884; Moore 1885; Eames 1885.
[107] Eames 1885: 326.
[108] *BMJ,* 2 (1884): 770.
[109] *BMJ*, 1 (1879): 668–69; White 1884; Moore 1885.

In many cases involving an insanity plea diagnosing mental disease could become a question of life and death for the accused.[110] Medical men also frequently testified in Probate Court on the validity of wills or on a person's ability to conduct their own affairs and manage their own money, property and personal life.[111]

Finally, compulsory instruction on insanity would attract more talented researchers and healers to the asylum system and, therefore, advance the whole area of medical psychology. Students who would not otherwise consider working with the insane might become interested after taking the compulsory course. New medical practitioners would be adequately prepared to approach research into mental pathology and advance knowledge about insanity even if they did not choose to work exclusively with mental patients.

In May 1879 the *BMJ* ran an anonymous article on the unsatisfactory state of the teaching of medical psychology in metropolitan schools and on the importance of knowledge of mental disease for all medical practitioners.[112] The author claimed that "[a]mongst the various duties which come within the scope of the medical man, there are few or none involving greater responsibilities, or which may be followed by more serious consequences to the community at large" than diagnosing, certifying and initiating treatment of insanity. The article also presented an interesting and compelling argument for why inclusion of mental disease in the compulsory curriculum was important for the entire medical profession. The author pointed to the ongoing debates about the Lunacy Law reform and the suggestion that, since most medical practitioners did not possess sufficient knowledge about mental disease, the power to issue certificates of insanity should be taken away from the medical profession at large and "placed in the hands of few experts".[113] The MPA and the *BMJ* editors strongly advised against this suggestion, although they agreed that the lack of knowledge was an important problem. However, their solution was the assimilation of medical psychology into general medicine. They expected that it would not only improve the system of certification of insanity but would also benefit the patients who in some cases would be able to receive treatment at home.[114] The negative view of the former proposal was signalled by the use of the word "experts" to denote the group who would gain exclusive rights to certify insanity. In the second half of the nineteenth century the term "expert" had a distinct negative connotation as it mostly referred

[110] *Lancet,* 124 (1884): 688; *BMJ,* 1 (1884)*:* 770. For more on medical testimony in criminal trials see R. Smith 1981, 1988, 1989; Eigen 1995, 1999, 2010, 2016; Bartlett 2001; Andrews 2010; Laragy 2013.
[111] *BMJ*, 1 (1879): 668–69. For more on medical testimony in civil cases see Moran 2019; Carson 2018; Hasson 2010; Degerman 2019.
[112] *BMJ*, 1 (1879): 668–69.
[113] Ibid.
[114] Ibid.

to expert witnesses in court cases and different select committees who often were paid for their pronouncements and usually had "direct financial interests in matters on which they pronounced".[115] The possibility of a conflict of interests and frequent cases when experts for different sides in court presented contradictory testimony led the public to doubt the experts' integrity.[116] The *BMJ* author's choice of this word was not accidental and aimed at raising the readers' anxiety about possible corruption within the ranks of medical profession were the supporters of the proposal to succeed.

Another argument put forward in the article was also concerned with a threat to the profession as a whole. The author claimed that, if compulsory and sufficient instruction on mental disease was not established as soon as possible,

> when the readjustment of power is made, it will assuredly not be made in favour of ignorance. Hence, unless a great reform be quickly instituted by our examining and teaching bodies, they must be prepared to find that the change will be in the direction of increased specialism — a specialism fostered and upheld by the law and necessitated by their own apathy.[117]

In other words, the article claimed that compulsory education on insanity would *prevent* specialisation, not advance it. According to this reasoning, if a subject became part of the compulsory curriculum, it became part of general medicine as all practitioners would be trained in it. Hence, adding mental diseases into the curriculum would be an act of resistance to specialisation. It would also avert the interference of "the public" and the state into medical affairs by granting special rights to a select group of medical practitioners. Lay legislation which proposed to impose internal divisions on the medical profession threatened its hard-won self-regulation: hence, it was important to avoid such precedents.

In August 1879, upon learning about the MPA's resolution to petition the GMC, the *BMJ* came out with a short article in support of it, saying that the BMA was satisfied "that the matter has been taken up by the Medico-Psychological Association, and that it has attracted notice of the Select Committee of the House of Commons, and is likely to be carried speedily to a satisfactory conclusion".[118] However, this prediction did not come true. The petition was considered by the GMC in July 1880 and rejected.[119] It took further five years and three more attempts at introducing medical psychology into the compulsory curriculum: the issue was

[115] Gooday 2008: 432.
[116] Carson 2018.
[117] *BMJ*, 1 (1879): 669.
[118] *BMJ*, 2 (1879): 265–66.
[119] *BMJ,* 2 (1880): 61.

raised again in 1882 and in 1884 before it finally passed in 1885.[120]

There were several reasons the GMC rejected the proposal. First, the council members were concerned that the four-year curriculum was already overloaded and that adding more compulsory subjects to it would cause the decline in quality of medical education overall.[121] They were also mindful that, if they agreed to make one specialist subject a requirement for obtaining a medical license, they would encourage other specialist medical communities to press for including their subjects too. This concern was shared by many medical practitioners outside of the GMC and expressed in a dramatic fashion by an Edinburgh practitioner J. C. Orchard in his article on medical education in the *Lancet*:

> At present the burdens laid upon medical students are by far too great, and by far too much is expected of them. […] We see specialists pressing to the front and demanding a course of lectures, with examinations, in their specialities. We see oculists demanding a course of lectures on diseases of the eye […]; others insist on a course of mental diseases. We may soon have aurists claiming a course on diseases of the ear, and dermatologists a course on diseases of the skin. Where is all this to end? Will no mercy be shown to the poor students?[122]

Some argued that compelling students to study mental disease as a necessary requirement for medical license was inappropriate to their level of study. During the 1880 discussion of the subject at the GMC meeting, a Scottish surgeon and an ex-president of the Royal College of Surgeons of Edinburgh Andrew Wood (1810–1881), who was actively involved in the council's subcommittee on education claimed that the "proper time to study such a subject [mental disease] was after a man had obtained the license or degree."[123] Surprisingly, this view was shared by James Crichton-Browne, who just a few years earlier enthusiastically taught medical psychology to undergraduate students in Leeds. In his address at the BMA meeting in 1880, he approved of the GMC's rejection of the MPA's petition and said that "[a] specialty in medicine — and psychological medicine is a natural and inevitable specialty — is a late differentiation of professional knowledge, and implied skill and attainments that should be sought for only after a liberal general training is complete."[124]

All of the above did not mean that the GMC did not consider knowledge of mental disease important for every medical practitioner. On the contrary, they claimed that basic

---

[120] *BMJ,* 2 (1882): 71; 2 (1884):770; 1 (1885): 1106.
[121] Ibid: 60.
[122] Orchard 1881: 51.
[123] *BMJ,* 2 (1880): 60.
[124] Crichton-Browne 1880: 262.

knowledge about insanity ought to be incorporated into the compulsory courses on clinical medicine, like all other types of illnesses. For example, William Gull, who studied under John Conolly at Hanwell in the 1840s and whose professional success was to a large degree caused by his work with the insane at the Guy's Hospital, argued that "it would be absurd to take up the course of mental disease apart from bodily afflictions".[125] Some other GMC members did not see the need to explicitly recommend compulsory study of mental diseases. For instance, Samuel Haughton, the representative for the University of Dublin, in the 1880 discussions and then again, in 1882, claimed that a similar proposal had been presented to his institution several times but "they had never yet seen any reason to adopt it".[126] In this respect his opinion was similar to Acland's in his interview with the Select Committee in 1878. When asked about the need for compulsory courses on insanity for all medical students, he shared the following personal anecdote:

> There was no compulsion in the matter [of studying insanity] when I was a student at Edinburgh; but I had the great advantage of constantly being at the Morningside Asylum, although nobody compelled me to be so. When my examination came on I was examined on the subject, and the examiner did not ask where I had learned what I knew.[127]

The GMC members noted that some licensing bodies had already included questions on insanity in their general medicine examinations and that many medical schools offered courses on mental disease.[128] If any student wished to learn more about the subject, they could take those courses, attend asylum wards, like Acland and Haughton, and read relevant literature. Again, the idea was that the students would understand the importance of familiarising themselves with mental diseases and find a way to do it, without official interference from the GMC.

The delicate balance of power between the GMC and the licensing bodies also influenced the way the proposals to add mental diseases to the list of recommended courses were handled. During the discussion in 1880, a few members of the Council suggested that, if the MPA convinced the licensing bodies to introduce an examination on mental disease as compulsory, the GMC would follow suit and include it into its recommended curriculum. The representative of the College of Surgeons of Ireland, Rawdon Macnamara, explained this

---

[125] *BMJ,* 2 (1880): 61.
[126] Ibid: 60.
[127] *Select Committee on Medical Act 1878–79*: 20.
[128] *BMJ,* 2 (1880): 60–61; 2 (1884): 770.

position further in 1882 by arguing that "the Council ought to hesitate before making a recommendation which must afterwards be practically disregarded"[129] and, again, in 1884 by positing that "[t]o adopt recommendations which they had no power to enforce was to lower the character of the Council".[130] He reminded the Council that to a large extent it had to rely on the good will of the licensing bodies in carrying out the GMC educational recommendation. Their only instrument of enforcing compliance was to appeal to the Privy Council to disenfranchise a non-compliant licensing body. But, first, they would need to convince the Privy Council that it was necessary and, second, it was much too serious a penalty for lack of compulsory instruction in one specialist course. Therefore, unless most licensing bodies agreed on the necessity of arranging instruction on mental diseases or hygiene or something else as a separate and essential subject, it would be unwise for the GMC to insist on it.

However, in addition to those general obstacles to the inclusion of mental diseases into the compulsory medical curriculum, there were two obstacles related specifically to medical psychology. Ironically, the first of them at the same time served as a reason to demand clinical training on insanity and as a reason to proclaim it impracticable, such as the fact that mental patients were not admitted into the wards of general teaching hospitals. As discussed earlier in this chapter, medical students could go through their entire course of study for qualification without encountering a single mental patient, which could lead to dire consequences for them and their patients in the future. Those who opposed compulsory instruction on insanity pointed out that the logistics of arranging the necessary clinical visits for big groups of students were difficult as they would have to go to asylums which were ill-equipped for handling large numbers of visitors.[131] However, clinical facilities to learn about insanity for a small number of keen students were available in or near most medical schools.

Finally, in 1880 William Gull argued that "still there were mental disorders, the cause of which could not be discovered, and the conditions of which were known no more than of the condition of the pure intellect".[132] In his opinion, the mental diseases which were known by the medical professionals had already been taught within courses on clinical medicine "but they could not go into medico-psychological questions".[133] This suggested that, at least to Gull, there was a difference in the quality of knowledge between medicine which dealt with "bodily afflictions" and psychological medicine. In this respect his claims were similar to Batty Tuke's

[129] *Lancet,* 120 (1882): 22.
[130] *BMJ*, 2 (1884): 770.
[131] *BMJ*, 2 (1880): 61; *Lancet,* 120 (1882): 21.
[132] *BMJ*, 2 (1880): 61.
[133] Ibid.

criticism of Laycock's teaching as excessively metaphysical and Henry Maudsley's warnings against looking for explanations of mental diseases in philosophy. According to Gull, "conditions of the pure intellect" were not a proper subject for the compulsory medical curriculum and not all students needed to go "to Hanwell or Bethlehem".[134] It could be concluded that he thought that the students should be taught only fundamental consensual medical knowledge leaving more controversial, specialised or under-researched subjects to extra-curricular study. James Crichton Browne adhered to a similar view, arguing that "the teachings on psychological medicine are still so ambiguous and unsystematic, that they can scarcely pretend to supply either much useful instruction or valuable discipline of mind."[135] Therefore medical men who "propose to devote themselves to lunacy practice" should be made to further their studies in this field after they pass their qualification examinations.[136] For all others the information on insanity covered in the courses on physiology, general medicine and medical jurisprudence should be sufficient until they gained more experience through their own medical practice.

4. The Determinants of Success

The reasons against making the course on mental disease compulsory looked almost insurmountable. However, in 1885, just a year after another motion to add insanity to the curriculum was rejected, it was brought up again and passed without serious resistance. Moreover, some of the councillors who previously spoke against it, such as Samuel Haughton, turned into vocal supporters of the proposal. Even the members who still had reservations did not argue against the necessity of the subject, only warned that the GMC should proceed with caution. For example, eminent Edinburgh surgeon and medical teacher Patrick Heron Watson (1832–1907) said that, although by agreeing to the motion the Council "would be trenching on specialisms […] he approved of clinical education in mental disease."[137] In this section I will discuss the reasons for this spectacular turnaround.

Doubtless, the MPA's relentless campaigning was essential for convincing the GMC. They successfully recruited the BMA and its journal, and the *Lancet* to their cause, which helped them reach large numbers of regular medical practitioners and keep the issue of instruction on insanity in the limelight for a decade. The MPA's activists also assessed the

[134] *BMJ*, 2 (1880): 61.
[135] Crichton Browne 1880: 262.
[136] Ibid.
[137] *BMJ,* 1 (1885): 1108.

balance of power between the GMC and the licensing bodies correctly. They started with an approach to the examination boards and with time managed to win a considerable amount of support from them. By 1885, the Royal College of Physicians of Edinburgh, the University of London, the Royal University of Ireland, the University of Dublin, the Faculty of Physicians and Surgeons of Glasgow, the Society of Apothecaries, and the Irish Branch Council had all expressed their approval of compulsory instruction on mental disease.[138] Although seven out of nineteen was not a majority it still was a considerable proportion of licensing bodies, and their voices were difficult to ignore. Finally, the MPA chose an auspicious time for their campaign and petitions: the select committees on medical education and on Lunacy Law, and several parliamentary bills to reform lunacy legislation attracted the attention of the government and lay publics to the issues of medical practitioners' competency to deal with insanity. All of the above put increasing pressure on the GMC to concede to the MPA's demands.

Another important factor was the generational change within the GMC and the medical elites. The younger generation of practitioners, who qualified in the 1860s or later and did not experience the earlier chaos of unregulated training seemed to be less vehemently opposed to specialist subjects unless there was suggestion of formal recognition of specialisation. By 1875 specialist departments in London general hospitals became common and many offered clinical training to interested students.[139] Medical specialisation had become well-established on the Continent, so even those practitioners who did not welcome it in Britain grew accustomed to the idea.[140] This mellowing of the anti-specialist sentiment was evident in 1885, when the GMC added "Theory and Practice of Vaccination" and "Hygiene" to the curriculum, alongside the course on mental disease.[141] For the case of medical psychology the most important change in the GMC composition was Andrew Wood's passing in 1881 and William Gull's retirement in 1883.[142] Especially the latter, as Gull was an influential practitioner with vast experience in treatment of insanity and a number of publications on the subject, and other GMC members recognised his authority.[143] Unfortunately for the MPA, Gull was also very conservative in his views on medical education and spoke against compulsory training on insanity. Hence, his withdrawal from the council significantly decreased opposition to the MPA's proposal.

---

[138] Eames 1885.
[139] Weisz 2006: 35.
[140] Ibid: 37.
[141] *BMJ,* 2 (1885): 476; *GMC Minutes,* 1885: 75–84, 89–91.
[142] *BMJ*, 1 (1881): 249, 2 (1883): 1285.
[143] Hunter and Greenberg 1956.

Although the above reasons were essential for the success of the campaign, they cannot explain the GMC's change of mind on the subject specifically in 1885. There was one more important factor which influenced their decision at that particular time. It was related to the emergence of a new style of journalism and the consequent transformation of the role of popular media in public life. The "New" Journalism, as it is commonly named in the literature, was characterised by a strong focus on personal interest stories, highly sensationalised reporting, melodramatic narratives, shocking exposés and titillating scandals.[144] The publications which espoused this type of journalism, such as the *Pall Mall Gazette*, *Truth* and *United Ireland* to name a few, appealed to the mass readership because their articles uncovered the sordid secrets of the rich and powerful and provided pitiful accounts of the hardships endured by the poor.[145] These publications also rejected the dry "objective" writing of older political newspapers like *The Times* and the *Telegraph;* instead they adopted a partisan and personal style of writing and aimed to mobilise their readership for political and social change.[146]

In the 1880s the attention of sensation-seeking journalists often turned to notorious court cases involving insanity pleas. If by that time controversial articles about abuses in lunatic asylums and wrongful confinement of sane persons in such institutions had become a familiar occurrence, the heightened interest in expert medical testimony was relatively new and alarming not just for the alienists but for the medical profession at large. Public disagreements between medical witnesses in court, especially delivered in a sensationalised manner, were potentially detrimental to the authority of all medical practitioners.[147] Unfortunately, the disagreements were not uncommon because the Anglo-American legal system itself provoked them by deliberately pitting the expert witnesses of prosecution and defence against each other rather that appointing a single non-partisan panel as was common in the rest of Europe.[148]

The plea of insanity in the 1880s in Britain was most commonly associated with murder trials. In the eyes of the public the indefinite confinement at a lunatic asylum, which followed a successful insanity defence, seemed harsher than any other punishments for non-capital crimes. Hence, it was mostly used when a conviction could result in an execution.[149] Furthermore, gruesome crime was one of the most common themes of New Journalism — it

[144] Brake 1988; Weiner 1988; Walkowitz 1992; Cohen 1993; Cocks 2003; Dawson 2004; Backus 2008; 2013.
[145] Walkowitz 1992: 84–85; Cocks 2003: 139–43.
[146] Walkowitz 1992: 81–119; Dawson 2004: 172–73.
[147] C. Jones 1994; R. Smith 1989; Carson 2018; Eigen 2016.
[148] Gooday 2008: 434; Carson 2018.
[149] R. Smith 1981b.

made for an excellent sensation and prolonged trials lent themselves to captivating serialised coverage.[150] Perhaps, the most famous of such cases was the assassination of the USA President James A. Garfield in 1882 and the subsequent trial of his murderer Charles Julius Guiteau. It was an international sensation which demonstrated one of the other important features of New Journalism: the advancements in communication technologies made fast transmission of the news from distant places to British readers possible.[151] This assassination was especially newsworthy because President Garfield lived seventy-nine days after he had been shot, keeping the public in suspense.[152] When Guiteau's trial started on 17 November 1882, the public's outrage at his action reached an extremely high degree and resulted in intense interest to the details of the trial. Guiteau's bizarre behaviour in the courtroom with sudden outbursts and frequent commentary on the behaviour of his attorney, prosecution, witnesses, judge and the jury added even more drama to the news coverage, as did several attempts on his life during the trial.[153]

Since Guiteau's defence was based on the plea of insanity, expert medical testimony played an important role in the trial. Twenty-four eminent medical practitioners testified and, not surprisingly, they disagreed amongst themselves on the accused's mental ability.[154] The prosecution's experts found the accused "sane, although eccentric" and noted that his conduct during medical examination was "different from his conduct in court, where his behaviour made the witness think that he [Guiteau] was playing a part."[155] The defence witness, Edward Charles Spitzka (1852–1914), a well-known American alienist, confidently proclaimed the accused insane and declared that "an expert who will testify that the prisoner was sane is either no expert or a dishonest one" and that "the narrow-minded official conducting the trial would find experts only too willing to chime in with the public opinion."[156]

The importance of such trials for defining what constituted insanity and how it was different from moral depravity and criminality has been discussed elsewhere.[157] However here I would like to draw attention to the implications for the medical profession as a whole. As historian Dan Degerman pointed out, the press coverage of court cases rarely used words like "alienist", instead they referred to people giving medical testimony as "physicians", "surgeons"

[150] Walkowitz 1992: 81–120, 191–228.
[151] Brake 1988; Weiner 1988.
[152] For a detailed history see Millard 2011.
[153] Millard 2011: 236–46.
[154] *JMS*, 28 (1882): 237.
[155] *Sheffield Daily Telegraph,* 20 December 1881, p. 2.
[156] *The Times*, 14 December 1881, p. 5.
[157] See for example: R. Smith 1981a, 1981b, 1988; Eigen 1999, 2010, 2016; Bartlett 2001; Moran 2019.

and "medical experts".[158] Indeed, in Guiteau's case as in many others the accused was examined by various medical practitioners, not just alienists. As in Britain, in the USA any qualified medical man was expected to be able to competently assess mental as well as physical health. Hence, critical newspaper articles about medical witnesses threw shade on the whole of medical profession, not just alienists.[159]

Guiteau's trial raised uncomfortable questions about the medical witnesses' integrity. The public animosity towards Guiteau was palpable; among the colourful epithets to describe him in the press were an "arrant rogue", "despicable being" and "moral monstrosity".[160] Hence, a large portion of the public viewed the testimonies of Guiteau's insanity as attempts by dishonest practitioners to interfere with the course of justice. The sentiment against Guiteau was so strong and the anxiety that he might escape execution so high that at least three attempts on his life were made during the trial.[161] On the other hand, some shared Spitzka's suspicion that the witnesses who insisted on Guiteau's sanity were simply pandering to the wishes of the vengeful masses. In both scenarios the medical profession would sustain a significant damage to its reputation. Patients' perception of their doctors' integrity was paramount for medical practice and authority. The conditions of medical treatment put a doctor into a convenient position to take advantage of their vulnerable patients if they were so inclined, especially when dealing with mental disease. If the stories of abuse and misconduct in asylums reflected poorly just on alienists, the stories from the courtroom put all medical practitioners under suspicion.

The alternative to lack of integrity — lack of expertise — was equally unacceptable because special knowledge about human illnesses and health was another crucial element of the legitimacy of medical profession. Patients had to be sure not only that their doctors had their best interests at heart but also that they were competent to diagnose and treat diseases. It did not help the reputation of the medical profession that one of Guiteau's tactics during the trial was to blame Garfield's death on his doctors, claiming that he only shot at the late president whereas the death was caused by medical malpractice.[162]

The British medical press discussed Guiteau's trial and its implications extensively. Naturally, the *Journal of Mental Science* published several long articles with the analysis of the case assessing the value of medical testimony and following the debates between American

[158] Degerman 2019: 466, n 2.
[159] Carson 2018; Dagerman 2019.
[160] *BMJ,* 1 (1882): 947; *The Times*, 28 June 1882, p. 11; *Sheffield Daily Telegraph,* 14 December 1881, p. 3.
[161] [Anon.] 1882: 26–27.
[162] Porter 1882: 36–37; [Anon.] 1882: 25.

alienists and neurologists.[163] General medical periodicals such as the *Lancet* and the *BMJ* also followed the case closely and printed several impassioned correspondence pieces. The fact that the whole debacle took place in the USA allowed British medical practitioners to be more vocal in their criticism as they could blame the embarrassing disagreement between the expert witnesses on the deficiencies of the American medical establishment and legal system. The *Lancet* called Guiteau's trial an "apotheosis of stupidity" and claimed that "no such *fiasco* of justice and common sense could have occurred in the old country."[164] Other professional periodicals stated similar views even if expressed in a milder style.[165] While responding to the American situation, some authors also offered cautious criticisms of the British system while maintaining that the fault was not with the medical profession. For example, one author pointed out that the British legal system was designed in a way which encouraged arguments between expert witnesses but did not provide a qualified arbiter to evaluate conflicting evidence:

> as long as the function of medical experts is confined to the giving of evidence, men will be found ready to advocate both sides in contested cases. There is no doubt, however, that a purely legal training does not enable a judge to discriminate nicely as to the value of this kind of evidence; and it is therefore most desirable that, when the question of [criminal] responsibility arises, a neutral medical assessor should be called in, or the question should be tried before some competent medical tribunal.[166]

The coverage of Guiteau's trial in the popular press alerted British medical elites to the dangers of sensational journalism for the reputation of the profession. Whereas when ridiculing American colleagues, the British medical press did not have to restrain itself, it had to be more careful when it came to problematic court cases at home. In the 1880s there were several notorious trials involving the pleas of insanity in which expert testimony was either conflicting or not sufficient and led to a verdict of sane and guilty — for example the cases of George Lamson, a morphinist and poisoner in 1882; Percy Lefroy Mapleton, "the railway murderer" in 1881; and William Gouldstone, "the Walthamstow murderer" in 1883. Both Lamson and Mapleton were often compared to Guiteau as murderers who tried to escape justice by pretending insanity, even though it was clear for anyone with enough common sense that both men were sane.[167] Lamson's trial was especially ironic as it was happening at the same time as

---

[163] *JMS*, 28 (1882): 236–43; 28 (1883): 577–81, 653–62.
[164] *Lancet,* 118 (1881): 1099; 1112.
[165] For example, *BMJ,* 1 (1882): 163–64; 1 (1882): 947–48.
[166] *BMJ*, 1 (1882): 164.
[167] See for example: *Worcestershire Chronicle,* 25 March 1882: 6; *Morpeth Herald,* 8 April 1882; *Bell's Life in*

Guiteau's and Chester A. Arthur, the new President of the USA, petitioned the British Home Office on behalf of the accused, saying that he should be spared capital punishment on account of insanity.[168] In the case of Gouldstone medical testimony did not convince the jury and he was convicted of murder but received a reprieve for the duration of a new medical inquiry into his sanity. In the end he was proclaimed insane and confined to Broadmoor Criminal Lunatic Asylum.[169] Compared to Guiteau's trial, these cases were less problematic for the medical profession: most of the witnesses were alienists and not generalists, and the trials were not political and did not involve famous people whose fate concerned the public.

However, there was one scandalous court case in 1883–4 which was so damaging that it prompted the GMC to reconsider its views on the necessity of compulsory instruction on mental disease. The case in question was the trial of James Ellis French, Detective Director of the Royal Irish Constabulary. It was a part of a much larger media sensation — the Dublin Castle scandal, an Irish homosexual sex scandal with far-reaching political implications. At the time the Irish Home Rule campaign was in full swing, and the Irish nationalists resorted to many tactics to advance their cause and discredit English authority, including sensational New Journalism.[170] Influential nationalist politicians and agitators Charles Stuart Parnell (1846–1891) and William O'Brien (1852–1928) founded their own newspaper *United Ireland* as an instrument of direct communication with the populace. This newspaper originated the scandal and added more fuel to its fire once it spread all over the UK press.[171]

The Dublin Castle scandal started with a series of anonymous articles in *United Ireland* about the "unnatural" sexual practices of some Crown officials, who governed Ireland from Dublin Castle, especially the head of detectives James Ellis French and the Chief Secretary of the Post Office, Gustavus Cornwall. The author of the publications has since been identified as Tim Healy (1855–1931), another nationalist politician known for his tendency to accuse Englishmen of sexual immorality.[172] Having been publicly accused of having sexual relations with other men, French and Cornwall had no other way to respond than to file libel suits against O'Brien, the editor of *United Ireland,* which was the intention of Healy and his political allies all along. Under the 1843 Libel Act it was possible for the defendants to win the suit if they

---

London and Sporting Chronicle, 8 April 1882: 7.
[168] See for example: *Pall Mall Gazette*, 31 March 1882: 8; *The Times*, 1 April 1882: 7; 3 April 1882: 9; *St. James's Gazette,* 3 April 1882: 3; *Freeman's Journal*, 5 April 1882: 7.
[169] See for example: *The Standard,* 28 September 1883: 5; 11 October 1883: 2.
[170] Earls 2019: 401.
[171] Earls 2019; Backus 2008; Cocks 2003: 115–54.
[172] Earls 2019: 401–02.

could prove that the information they published was true and important for the public.[173] O'Brien prepared for the trial by gathering evidence and searching for witnesses to testify in court to the truth of Healy's accounts.[174] The importance to the public was easier to establish: sodomy was considered a matter of great public concern, as was moral corruption of the country's administrators.

By the time the libel trials commenced (Cornwall's in April 1884 and French's in June 1884) O'Brien had found twenty-two witnesses many of whom would testify to having had sex with French, Cornwall or both of them.[175] The testimony against both officials was overwhelming. It did not only serve as an effective defence of O'Brien and *United Ireland* but also convinced the judge to indict French, Cornwall and a few of their accomplices on criminal charges of sodomy. The judge found the witnesses' testimony so disturbing that he ordered the court transcripts destroyed.[176] The libel trials and the subsequent criminal trials were closely followed by the Irish and British press, so it is still possible to reconstruct the events and rhetoric of the court proceedings. The Dublin Castle scandal had far-reaching political and legal consequences: it helped the Irish Parliamentary Party gain more seats in the 1885 parliamentary election; aided the passing of the Labouchere Amendment, which made "gross indecency" a crime in the UK; and "defined the conventions of the homosexual sex scandals that would prevail […] for decades to follow".[177] The latter becomes especially obvious when we look at the trial of Oscar Wilde which developed in a very similar way to the Dublin Castle scandal.[178]

The connection of the scandal to medical psychology and medical education has been an under-explored aspect. After French was indicted on criminal charges his defence took an unusual strategy. His barrister claimed that French was insane and, thus, unable to plead or direct his defence in court. The difference from the usual insanity plea was that it did not state that French was insane at the time of committing a crime but that his mind was unsound at the time of the trial and, regardless of his guilt or innocence, the court could not proceed with the case.[179] It was also unusual because it was used in a case of a non-capital offence. According to the 1861 Offences Against the Person Act the maximum sentence for sodomy was life

[173] Earls 2019: 402; Cohen 1993: 126–29.
[174] Earls 2019: 402; Cocks 2003: 140.
[175] Earls 2019: 402.
[176] Ibid: 403.
[177] Backus 2008: 109; Earls 2019.
[178] See, for example, Cohen 1993.
[179] *Freeman's Journal*, 20 August 1884, p. 3; *Belfast News-Letter*, 20 August 1884, p. 7–8.

imprisonment.[180] Whereas, if the jury found French mentally unfit to stand trial, he would "be put back [into custody] and confined practically as a criminal lunatic. He might be discharged cured, but he would then be put forward to plead again, no matter what length of time might elapse".[181] Hence, the success of the insanity strategy would not lessen his punishment and might even exacerbate it.[182]

Unusual or not, the jury was empanelled, and the court proceedings commenced. Both sides employed several medical witnesses to testify to French's mental capacity. Unsurprisingly, they disagreed. Among the experts testifying to French's insanity were two eminent practitioners: James Alexander Eames — a renowned alienist with over 20 years of experience, superintendent of the Cork Lunatic Asylum who went on to become the President of MPA in 1885 and a lecturer on psychological medicine in Queen's College, Cork;[183] and William Ireland Wheeler — President of the Royal College of Surgeons in Ireland in 1883–4, a popular teacher of surgery and author of numerous research papers in medical journals.[184] The prosecution's witnesses were just as illustrious: "all men of the highest order of intellect — apart from their scientific knowledge and their special qualification to form a judgement."[185] Experts for the Crown were: Robert McDonnell — FRS, a celebrated surgeon, medical researcher, teacher and writer and formerly superintendent of the Mountjoy prison;[186] John Thomas Banks — physician to the Queen in Ireland, regius professor of medicine at Trinity College, Dublin, and its representative on the GMC, and a visiting physician to the Richmond Lunatic Asylum;[187] and Francis Cruise — at the time president of the Royal College of Physicians in Ireland, inventor of the endoscope, visiting physician to a lunatic asylum and a researcher of hypnotism.[188] This group of experts was so distinguished that they were nicknamed "the Viceregal Commission" in the press.[189]

One of French's defence strategies was to question the Viceregal Commission's authority in mental disease, and the Crown threw doubt on the defence's medical witnesses' ability to detect malingering. The experts were deliberately pitted against each other and asked

---

[180] Earls 2019: 399.
[181] *Freeman's Journal*, 20 August 1884, p. 4.
[182] It appears that French was planning to wait out the scandal and the coming election, hoping that without scrutiny from the press he would receive help from his superiors or the English officials.
[183] *JMS*, 32 (1886): 461–62; *Lancet*, 128 (1886): 193.
[184] *Lancet*, 154 (1899): 1621; *BMJ,* 2 (1899): 1589.
[185] *Freeman's Journal*, 20 August 1884, p. 4.
[186] *DNB.*
[187] Ibid.
[188] *BMJ*, 1 (1912): 586; *Lancet*, 179 (1912): 694.
[189] *Freeman's Journal*, 20 August 1884, p. 3.

explicitly to agree or disagree with the conclusions of others; for example, Banks was asked if he agreed with Wheeler's claims.[190] They were also asked to explain the foundation of their diagnosis. The expert witnesses delivered their testimony in a remarkably guarded way, qualifying their statements which annoyed the judge who asked many direct clarifying questions and even addressed the issue openly by saying: "You, medical men, speak so gently, it is sometimes difficult to catch exactly what you say. Treat me and the jury as if we were perfectly sound (a laugh)."[191] All was in vain, the witnesses kept to their original opposite positions. As one of the medical witness, McDonnell, put it, "[o]ne doctor goes one way, and another goes another".[192] In the end, the judge encouraged the jurymen to critically question medical testimony and noted that "doctors might not only differ but they might be wrong".[193] Nevertheless, the jury was so confused by the disagreement between the medical experts that they did not manage to reach a verdict, even though the judge insisted they tried and sent them back to deliberate four times. The case had to be retried.

This conflict of medical testimony elicited a pointed response from the press. That day the editorial of *Freeman's Journal*, a popular nationalist-leaning Irish newspaper, was dedicated specifically to the disagreement between the experts and cautioned its readers to evaluate the testimony and qualifications of medical men carefully keeping in mind that "we must not overlook the fact that even the most honourable and upright men are, with perfectly pure intent, insensibly influenced towards the side by which they are employed."[194] The newspaper also commented on the quality of evidence the medical witnesses offered to support their claims: "we have been much struck by the comparatively negative character of the testimony offered on one side by the absence of a definite attempt to settle on a disease, and by the loose — or at least careless — use of specialist and unclear terminology, whereas medical practitioners appointed by the Crown, "have certainly given an amount of testimony of a positive character which is entitled to the very gravest consideration."[195] Nevertheless, the situation was very awkward for the medical profession; even the judge, who was supposed to be impartial "confessed he was never more embarrassed in a case, there being such a conflict of evidence on the part of men whom he knew personally and whose opinion he valued."[196] The London newspaper *Truth* went even further in its assessment of the situation: attacking

[190] Ibid: 4.
[191] Ibid.
[192] Ibid.
[193] Ibid.
[194] *Freeman's Journal*, 20 August 1884, p. 1.
[195] Ibid.
[196] *Glasgow Herald*, 22 August 1884, p. 6.

established authorities with its usual ardour, it stated that French's case demonstrated "[t] he utter worthlessness of what is known as expert medical evidence". The anonymous author ended his article by saying that "[p]ersonally I am disposed to regret that it was not possible to shut up the doctors instead of the jury and to keep them in close confinement until they managed to agree".[197]

After the second trial on 31 August 1884 the situation deteriorated further. The testimony of medical witnesses stayed the same, but the Crown was more aggressive in questioning the defence witnesses' evidence. For example, Dr Curtis, when pressed to "give any data" from which he had arrived at his conclusion that French was insane, had to answer "I cannot".[198] Even more crucially, the prosecution presented to the jury an intercepted letter from French to his friend, in which he explained what had to be done for his defence and presented his assessment of the state of the case. This letter was a much more decisive piece of evidence than all of the expert testimony. As the *Derry Journal* mocked, "[t]he contents [of the letter] did not, of course, affect the conclusions of the medical experts called by the prisoner, but they were probably the only persons present who were not fully convinced that the document in question was the work a very able man in the full possession of his faculties."[199] This time the jury took only ten minutes to deliberate and returned with the verdict that French was sane and able to plead.[200]

Freeman's Journal dedicated another editorial to discussion of the case and, especially, to the criticism of the medical testimony in court. The piece cautioned the public against treating such evidence with too much reverence and claimed that the lay jury's common sense was at least just as useful as medical opinion for making a judgement in the cases like French's. The editorial concluded its assessment of the whole situation in the following way:

> A skilful malingerer led a number of reputable gentlemen into a maze of feigned disease, and fairly puzzled them to such an extent that they gave a mass of evidence which, we believe, if carefully analysed by a competent medical jurist, might show itself to be incongruous, inharmonious, and irreconcilable; faulty in its facts and wrong as to its deductions.[201]

The relentless criticism of medical testimony in the case of French alarmed Irish medical elites because it did not just attack alienists but questioned the value of expert medical witness

---

[197] Quoted from *Freeman's Journal*, 28 August 1884, p. 6.
[198] *Freeman's Journal,* 31 August 1884, p. 3.
[199] *Derry Journal*, 5 November 1884, p. 3.
[200] *Freeman's Journal,* 31 August 1884, p. 3.
[201] Ibid*,* p. 5

altogether. It also raised uncomfortable questions about the quality of medical knowledge and whether in some cases a layman's opinion was just as good as doctor's because, if medical testimony were grounded in scientific facts, surely, such disagreements as those in the trials of French would not be possible.[202]

When at the next meeting of the GMC the matter of making the teaching of mental disease compulsory was raised again the representative of the University of Dublin, Samuel Haughton, who had always opposed such motions in the past, actively argued for its passing. His reasoning for this change of heart was that the

> recent trials in Dublin had in a terrible manner raised this question of mental disease. It was scandalous to the medical profession to find witness after witness called up, some to swear that the accused was insane, and others that he was shamming.[203]

Making sure that all of the medical practitioners around the UK received compulsory instruction on insanity would eliminate the possibility of such scandalous disagreements. Banks, who was also present at the meeting, noted that several licensing bodies in England, Scotland and Ireland had already considered the subject compulsory for their medical examinations. After a short discussion, the motion was passed to "add mental disease to the list of subjects" recommended by the GMC.[204] The MPA's campaign succeeded.

Conclusion

The most important aspect of the development of education on insanity in the 1870s and 1880s was the MPA's campaign to include it in compulsory medical curriculum. Analysing this process through the interplay of interests of various groups of stakeholders makes clearer the reasons for the successes and failures of the campaign.

The system of medical education in Britain in 1876–1886 remained complex and difficult to navigate but, unlike earlier in the century, it was united by the single compulsory curriculum recommended by the GMC. The establishment and reform of the curriculum was a difficult task as it had to reconcile conflicting interests of the state, of the various licensing bodies and, to an extent, of the medical students and teachers. To add an additional compulsory subject the MPA had to convince of the majority of the medical community that it was to their advantage.

---

[202] Ibid.
[203] *BMJ*, 1 (1885): 1106.
[204] Ibid.

In the 1870s and 1880s British alienists were beset by many difficult problems. Their work was encumbered by the existing Lunacy Law and the local governments' demands to economise. The asylum system did not deliver on its promise to cure insanity, and the mental institutions were rapidly turning into warehouses of chronic lunatics. The competence and professional integrity of alienists were constantly questioned in the press and by lay activists. Several widely publicised court cases and journalist investigations brought additional scrutiny and ridicule to the asylum practitioners. The position of medical psychology at the time was precarious and establishing compulsory instruction on inanity was one of the strategies to improve the situation.

To achieve this goal, the MPA's campaign had to overcome the GMC's objections to including mental disease in the curriculum. The GMC had to make sure that the study of medicine was manageable and attracted a sufficient number of students to provide medical services to the military and civilian population. The recommended curriculum aimed to define an absolute minimum of knowledge and skills necessary to practice medicine safely. They tried to avoid any subjects which did not seem necessary. Moreover, the GMC did not forcefully dictate teaching requirements to the licensing bodies and whenever possible left it to them to decide how to best instruct their students. Furthermore, most British medical practitioners opposed specialisation of medicine. They did not want to add special subjects to the standard curriculum to avoid lending legitimacy to fledgling specialisms. Instead, they argued for covering as many matters as possible in general medical subjects, such as clinical medicine.

Some of the obstacles to mental disease becoming a compulsory course were related specifically to medical psychology. As in the earlier periods, the necessity to arrange instruction in the asylums seemed impracticable to some people. The logistics of arranging the course for a large number of students were considered excessively complicated. Some eminent medical men doubted the quality of medico-psychological knowledge claiming that a large part of it was speculative and rested on metaphysics and psychology rather than on hard medical facts. They considered that the actual medical knowledge could be easily communicated to the students during the course on clinical medicine and the rest was not essential for safe practice and could be studied as an elective course or after qualification.

However, the MPA's campaign for compulsory education on insanity was remarkably successful given the obstacles it had to overcome. It found supporters within professional associations, licensing bodies and influential medical periodicals, such as the *BMJ* and the *Lancet*. John Alfred Lush, a prominent alienist and an MP was appointed to the select committee on medical education and attracted attention of the House of Commons to the need

for instruction on insanity. The campaign was helped further by the generational change within the GMC and medical elites. The new younger members were less inclined to oppose specialisation at any cost and often generally held more progressive views.

Finally, the sensationalised newspaper coverage of infamous court cases in which medical witnesses gave opposing testimony alerted the GMC members and other influential medical practitioners to the importance of controlling the reputation of their profession in the media. The Dublin Castle scandal of 1883–1884, and particularly the trials of James Ellis French, had an especially powerful effect on some of the most obstinate members of the GMC. They believed that compulsory training would prevent such contradictions in medical testimony and spare medical profession more disgrace in the future.

Therefore, the success of 1885 can thus be explained by a complex of factors, some a result of deliberate effort while others were the products of good timing and fortunate coincidence.

Chapter 5. Specialist Training: Psychiatry beyond the Undergraduate Curriculum, 1887–1914

Introduction

"It is now generally granted that a post-graduate training for medical men desirous of taking up lunacy as a speciality is essential" wrote Edinburgh alienist David Orr in 1912.[1] This quote illustrated a profound change which took place in British medicine between 1887 and 1914: the replacement of stubborn resistance to medical specialisation with its general acceptance. By the 1910s the need for some form of specialist postgraduate training of medical practitioners had been recognised by most medical practitioners.[2] Two registrable diplomas had been established — in public health and in tropical diseases — and a host of less formal courses and certificates had become available.[3] This chapter will describe the history of two postgraduate qualifications in mental diseases developed by the MPA between 1887 and 1914.

In the 1880s the MPA embarked on another educational endeavour — the development of its own qualification entitled the Certificate in Psychological Medicine (CPM). British alienists hoped that it would help them to increase the authority and prestige of their profession, bring public recognition of their expertise, establish the standard of good training on mental disease and encourage talented practitioners to take jobs in lunatic asylums and engage in research on insanity. The specially created Education Committee of the MPA was tasked with developing the curriculum and the procedure for certification. Similarly to the GMC's approach to the compulsory medical curriculum, the MPA chose the strategy of defining the minimum of knowledge and skill for safe practice and designed the CPM to ensure that level of training.

The first CPM examination took place in 1887 and just a few years later it became clear to the MPA that the qualification would not live up to their expectations. After several attempts to remedy the situation, the Education Committee recommended discontinuing the certificate in 1905. Since then, it has been considered a failure by both the historical actors and historians alike.[4] In some ways it was a fair assessment, especially if we compare the CPM to another

[1] Orr 1912: 39.
[2] Weisz 2006: 164–90; Hanley 2015.
[3] Weisz 2006: 167; Hanley 2015.
[4] See, for example, Bynum 1991: 176; Crammer 1996: 220–21; Bewley 2008: 126; Lewis 1967: 115–16; Thomson 1908: 578; *JMS,* 51 (1905): 780.

certification scheme developed by the MPA — the Mental Nursing Certificate, founded in 1891. The CPM struggled to attract candidates, did not gain recognition outside of the alienists' community and had no effect on medical research into mental diseases. However, it served as an important step towards the establishment of the MPA as an educational and certification authority and provided important insights for the development of future specialist training in psychiatry.

The main reasons for the CPM's lack of success were that it did not address the training needs of young medical practitioners and failed to capitalise on the emerging trends in medical pedagogy and structural changes within British medicine. At the time when there appeared a new demand for regulating medical specialisms and providing specialist medical training, the MPA chose an outdated and conservative strategy in trying to design their certificate to appeal to all medical practitioners. The CPM duplicated the curriculum for compulsory instruction on insanity, did not offer tangible career advantages and was not rigorous or intellectually challenging. The holder of the CPM could not claim the possession of any additional expertise in mental diseases beyond the standard medical curriculum. Hence, there was little incentive to take the examination.

The failure of the CPM did not deter the MPA from attempting to develop another postgraduate qualification — the Diploma in Psychological Medicine (DPM) — in the beginning of the twentieth century. In developing the new scheme, the MPA considered the flaws of the CPM and the needs of the young medical practitioners and junior medical officers in the asylum system. The DPM offered a rigorous and comprehensive programme of specialist training which, even though it could not yet offer formal recognition, clearly distinguished the holders of the diploma as highly trained specialists in psychiatry, whose expertise far exceeded the knowledge imparted by compulsory medical education. The new programme was largely inspired by the German system of training which was greatly admired by most British alienists at the time. The interest in the German approach to education and research on mental disease was reflected in the acceptance of the term "psychiatry" to denote the medical specialism related to mental illness.[5] The MPA also launched a campaign for profound changes of the lunacy system in Britain with many suggestions also borrowed from the example of Germany: the establishment of outpatient centres and clinics for acute cases, the connection of psychiatric units to university medical schools and improvement of the position of junior asylum officers.

[5] The terms "medical psychology" and "psychological medicine" were still in use too, hence I will employ all of them interchangeably in this chapter.

This chapter consists of four sections. Section 1 will be dedicated to the development of the CPM, the reasons for its establishment and the challenges faced by the MPA in designing and implementing its own certification. In Section 2 we will evaluate the advantages and disadvantages of the CPM and compare it to the Mental Nursing Certificate which was considered a resounding success. Section 3 will explain why the CPM failed to achieve its objectives and provide reasons why the MPA's attempts to improve it did not work as expected. Finally, Section 4 will describe the new postgraduate psychiatric qualification, the DPM, and demonstrate how it addressed the needs of medical practitioners and avoided the problems which defeated the CPM. In line with the periodic themes explored in previous chapters, this chapter thus considers the development of postgraduate training in Britain at the turn of the century as a process coloured by the issue of specialism in psychiatry. The question of how specialised education and examination, and indeed practitioners in psychiatry themselves should be, was central to debates amongst the MPA at this time and, as we will see, revealed rifts between members of different generations and so on. Only when the nature of psychiatric specialisation became widely accepted, in the new century, was a successful programme of postgraduate qualification achieved.

1. The CPM: Establishment, Programme and Objectives

In the 1880s, alongside campaigning for compulsory instruction on insanity the MPA was working on another educational project — the establishment of a specialist qualification in medical psychology. Although the GMC agreed to include mental disease in the recommended curriculum, the content, form of instruction and format of examination, if any, remained to be decided by each licensing body; the MPA had no control over it. Hence, they decided to develop their own certification programme with all aspects of it designed by the alienists themselves. The first examination for the Certificate in Psychological Medicine (CPM) took place in 1887 and repeated every year until 1914. In this section, I will explain the reasons for its establishment, describe the curriculum and procedure of the examination, and the challenges faced by the MPA in the process of creating the CPM.

In February 1885 the MPA Council appointed a sub-committee "to consider the question of granting by the Association of certificates in psychological medicine".[6] Sadly, none of the Council's pre-1887 minutes have survived, so we do not know who and how proposed

[6] *JMS*, 31 (1885): 276.

this and what specific goals were set before the sub-committee. However, from the available records we know that, first, this was happening alongside the MPA's campaign for inclusion of mental disease into the standard curriculum. The GMC agreed to the MPA's proposal in May 1885. Hence, in February the MPA Council had not yet been sure of the success with the GMC and, judging by their previous track record, it was entirely possible that the motion would fail again. Secondly, George Henry Savage (1842–1921) and several other alienists who were also members of the Royal College of Physicians, attempted to establish a postgraduate certificate in mental disease at the RCP, similar to the certification in hygiene, which had been recently started at the College.[7] They did not succeed, as some of the RCP members felt very strongly that "it [would be] a mistake to have a special examination in lunacy, and that lunacy should be part and parcel of what was expected in the qualification of physician, not apart from it, but conjoined with it".[8] The RCP membership examination included questions on mental disease and this was sufficient, as far as the College was concerned.

These two factors and the discussions at the MPA meetings suggest that at least one of the reasons for establishing the MPA's own certificate in psychological medicine was to have a back-up plan in case all other educational initiatives failed. Furthermore, creating an independent qualification provided the alienists with an opportunity to consider all aspects of it freely and create a programme they themselves considered optimal. The MPA could then share it with other medical organisations as a standard of good educational practice.[9]

Another important consideration was the active campaign for Lunacy Law reform. As discussed in the previous chapter, certification of insanity by medical practitioners with no special training on mental diseases was a sore subject. Medical men were unhappy with it because it made them liable in cases when the alleged lunatics considered themselves unlawfully imprisoned.[10] The public was concerned because they feared unlawful imprisonment.[11] The asylum doctors were dissatisfied because this whole issue tarnished their reputation and devalued their allegedly superior expertise.[12] Therefore most of the bills to amend Lunacy Law had clauses on changing the certification procedure. It seemed possible that the new law might leave the power of granting lunacy certificates exclusively to specially trained medical practitioners. In this case a new problem would arise: the absence of a

[7] *JMS*, 31 (1885): 433.
[8] Ibid.
[9] Ibid.
[10] See, for example, *Lancet*, 128 (1886): 487–88; *BMJ,* 2 (1884): 1148–49; *JMS,* 32 (1887): 529–35.
[11] McCandless 1989; Brückner 2021; *Lancet*, 123 (1884): 536–37; *BMJ,* 1 (1882): 101–02.
[12] Eames 1885*; JMS,* 24 (1879): 73–74; 30 (1884): 411–15; 32 (1886): 70–72.

recognised training programme on insanity. To take advantage of the situation the MPA needed to develop such a programme. It was declared

> if future legislation took place it would be a very good thing for the Association to be able to say to whoever would be drawing up the next Bill: "We are distinctly prepared to examine men and to give some guarantee to their fitness for giving judgement in cases of lunacy."[13]

If this plan came true, the MPA would acquire a much more important place in British society and alienists would gain recognition as the ultimate experts on insanity.

Finally, having their own certificate gave the MPA full control over shaping the curriculum and the standards of knowledge and practice in psychological medicine. Furthermore, by making it compulsory to attend clinical lectures on insanity or reside in an asylum the Association members made sure that asylum doctors would serve as both the teachers and the examiners for the new certificate. Thus, when the question of a special qualification arose again in August 1885, even after the GMC finally recommended to make the subject of mental disease compulsory, the MPA members decided that it was "very desirable to take steps to carry out" the plan of establishing the Certificate in Psychological Medicine."[14] The MPA Education Committee, appointed earlier that year, presented the certification scheme they had developed, and judging by the length of the minutes taken at the meeting, the discussion of the certificate took a significant part of the day.[15]

The Education Committee, chaired by Daniel Hack Tuke (1827–1895), one of the authors of the first British textbook on medical psychology and one of the first teachers on mental disease in England, proposed the following regulations for the examination:

> XI. Candidates must be at least 25 years of age.
>
> II. They must produce a Certificate of having resided in an asylum (affording sufficient opportunities for the study of mental disorders) for six months, or of having attended a course of lectures and the practice of an asylum where there is clinical teaching, for not less than three months.
>
> III. They must be Registered under the Medical Act (1858).
>
> IV. The Examination to be held twice a year, at such times as shall be most convenient, in London, Scotland, and Ireland.
>
> V. The Examination to be written and oral, including the actual examination of insane patients.

---

[13] *JMS*, 31 (1885): 433.
[14] Ibid: 432.
[15] *JMS*, 31 (1885): 276.

VI. The fee for the Examination to be fixed at £5 5s., to be paid to the Treasurer, for any expenditure incurred, including the Examiners' Fees.

VII. Candidates failing in the Examination to be allowed to present themselves again at the next and subsequent Examinations on payment of a fee of £3 3s.

VIII. The Certificate awarded to the successful candidates to be entitled "Certificate in Psychological Medicine of the Medico-Psychological Association of Great Britain and Ireland."

IX. Candidates intending to present themselves for Examination to give Fourteen Days' Notice in writing either to the General Secretary of the Association, the Secretary for Scotland, or Secretary for Ireland, according as he desired to be examined in London, Edinburgh, or Dublin.

X. The Examiners shall be two in number for England and Wales, for Scotland, and for Ireland.

XI. They shall be appointed annually by the Council of the Association from Members of the Association. They shall not hold office for more than two years in succession.[16]

Immediately some attendees of the meeting took issue with Clause II. They considered the requirement of a half-year residence in an asylum too long, their objections reflecting their ideas about prospective candidates for the new certificates. For example, an Irish alienist Oscar T. Woods, thought that it was unreasonable to demand such a long period of residence at an institution for the insane because most people who would apply for the certificate would be established medical practitioners "who seek recognition of their ability to speak on insanity and give evidence in trials and opinion in cases."[17] In his opinion, those gentlemen would not be able to comply with the requirement of such a long residence in an asylum and, therefore, would have no access to the qualification.

On the other hand, James Eames, the MPA President at the time and one of the medical witnesses for the defence in French's trial, thought that requiring candidates to either reside in an asylum for six months or attend "a course of lectures and the practice of an asylum where there is clinical teaching" for three months would make the certificate impossible to achieve for practitioners who either could not afford putting this much time and money into the study of insanity (presumably, younger less established practitioners) or those, who had no access to a teaching asylum in their area.[18] Eames pointed out that in Ireland there were only three large asylums which offered clinical teaching: in Cork, Dublin and Belfast. Practitioners from more remote areas could not visit those but may be able and willing to attend their local asylums or work with the insane in some other capacity. Yet other members, like the superintendent of the

[16] *JMS*, 31 (1885): 432–33.
[17] Ibid: 434.
[18] Ibid.

Crichton Royal Institution James Rutherford, and Thomas Clouston, suggested that the time of residence be reduced to three months because it was the standard period of clinical clerkships.[19] This suggested that they expected that the examination would be taken by newly qualified practitioners because clerkships were usually taken soon after medical registration, since they were the most junior and usually unsalaried posts.

Hence, there were at least three different ideas of who constituted the primary target audience for the CPM: one, established professionals who sought to advance their career as consultants and medical witnesses; two, poorer provincial practitioners who wanted to expand their practice into working with the insane in private practice; and three, young practitioners just out of medical schools who either aimed at an asylum career or considered experience with lunacy an asset for other employment. Although the advocates on behalf of those groups essentially asked for the same thing — relaxation of the rules in Clause II, it is interesting how they did not pay much attention to other requirements which could disadvantage the same groups of people. For example, the price of the certificate was quite steep for a recently qualified practitioner or a poorer provincial doctor. The minimum age of certification was set at 25, whereas the minimum age of medical registration was 21, which would suggest that many of the young practitioners would not be able to take the examination for CPM right after graduation or completing their clerkship and would have to wait a few years.

There was no real opposition to the relaxation of the rule although several members expressed concern that it was important to make sure that the candidates were competent and had sufficient experience, otherwise the certificate would not serve its purpose. Rutherford specifically stressed that "some distinction should be made between simply walking round the wards of any asylum and actual residence or lectures with genuine instruction."[20] It was finally decided that the feedback from the general meeting would be communicated to the MPA Council which would make the final decision. The Council was receptive to the members' arguments and the notice about the new certificate contained amended Clause II:

> They [candidates] must produce a certificate of having resided in an asylum (affording sufficient opportunity for the study of mental disorders) as Clinical Clerk or Assistant Medical Officer for at least three months, or of having attended a course of Lectures on Insanity and the practice of an asylum (where there is clinical teaching) for a like period.

[19] Ibid.
[20] Ibid: 435.

This tension between making the certificate as accessible and popular as possible with British and Irish medical practitioners, and maintaining high standards for passing, remained a constant throughout the existence of the CPM. Its first year was especially illustrative of the issue. The dates for the first examinations in 1886 were set for January in Dublin, March in London and July in Edinburgh.[21] However, no candidates presented themselves at any of them.[22] This failure to take off was at least partly attributable to lack of publicity: it took time for the news of the certificate to spread. The *BMJ* published a long piece on the institution of the certificates in early March 1886 and the *Lancet* mentioned it in their notices about the MPA meetings, but this would have been too short a notice for most eligible candidates.[23] However, the main reason for lack of interest, according to the members of the MPA, was that the requirements were too demanding.

Therefore, at the next annual meeting the MPA made several changes to the certificate to make it more appealing. First, the MPA Council realised that the age requirement prevented candidates "who might otherwise have suitably applied for the diploma" from doing so.[24] Hence, they lowered the age threshold to 21 provided the candidates fulfilled other requirements. Secondly, on Thomas Clouston's suggestion the MPA agreed to allow medical students apply for the certificate before they fully registered. Then medical students could take the CPM exam at the same time as their finals at medical schools. It was important because "after receiving their degrees they [medical students] might be going away all over the world, and would not be in a condition to subsequently pass."[25] In case such pre-qualification candidates succeeded at the CPM exam their certificates would be withheld until they properly registered under the 1858 Medical Act. Finally, the contentious Clause II was amended again, this time to allow candidates who did not reside in an asylum for the required time and did not attend appropriate lectures but considered themselves in possession of sufficient experience in insanity to present evidence of their competency to the MPA president.[26] If he deemed it sufficient then the candidate would be admitted to the examination. The people this amendment was supposed to attract were the medical practitioners who might not have had asylum experience but nonetheless had to work with the insane regularly, for example, medical officers in workhouses, and could benefit from an additional qualification.[27] Finally, the examination

[21] *JMS,* 31 (1885): issue 135 back matter.
[22] *JMS*, 32 (1886): 455.
[23] *BMJ*, 1 (1886): 474; *Lancet*, 126 (1885): 323.
[24] *JMS*, 32 (1886): 455.
[25] Ibid.
[26] Ibid.
[27] Ibid: 456.

fee was reduced from five to three guineas to make it more affordable.[28]

These changes, the increased publicity and the asylum superintendents' encouragement of their assistants and clerks to take the CPM exam achieved the desired result. At the next session 14 people passed the examination and were granted the CPM.[29] Sadly, the information on how many candidates entered examination thereafter and the rate of success is only available from 1893 onward. However, the MPA financial reports included the amounts paid as fees for examination and, judging from this data, it seems that in the period between 1887 and 1892 the CPM examination success rate was 100%. This would suggest that the exam was not excessively difficult.

For the first few years it was left to the examiners to set the examination questions for their region but in 1891 the question of uniformity of the examinations for the CPM was raised.[30] It was suggested that written examinations at all locations should be scheduled for the same day and use the same questions. Then the examiners could determine a convenient date for the *viva voce* part and were not required to be present at the written examination. If the questions were set in advance, a superintendent at a local asylum could act as an invigilator during the exam and simply send the finished papers to the examiners for marking.[31] Thomas Clouston strongly opposed this proposal, and the motion did not pass. He argued that changing arrangements to the same date and the same questions everywhere would decrease the number of applicants for the CPM.[32] A large proportion of candidates came from Clouston's course at the University of Edinburgh, and he used the same questions for his end-of-course exam as the written part of the CPM exam. His students then had an option to pay an extra fee of three guineas, have their exam papers count towards the CPM and only pass the *viva voce* in addition to their coursework. This was a convenient scheme and Clouston claimed that if the questions had to be uniform across the UK it would be impossible to use them as the exam for his students because they might not match his teaching. Curiously, he did not consider changing his instruction to fit the questions of the CPM exam.

Stranger still, Clouston's argument convinced other members of the MPA to vote against the proposal. One of the main declared reasons for establishing the CPM was to guarantee sufficient training and consistent level of proficiency amongst all holders of the certificate. If Clouston's claim was true it would mean that there were such great differences

[28] Ibid.
[29] *JMS,* 33 (1887): 480–82.
[30] *JMS,* 37 (1891): 639–58.
[31] Ibid: 649–50.
[32] Ibid: 650.

in teaching between different countries of the UK that they necessitated different examination questions. However, such divergent examinations would defeat the purpose of the certificate. Another possibility was that he considered his course to be more advanced than teaching at other places and an exam which would suffice for another medical school would not be challenging enough for his students. However, this too would go against the idea of setting a standard of necessary knowledge about insanity. Moreover, it would put Clouston's students at a disadvantage since they would be required to pass a more difficult exam.

Even though in 1891 the suggestion to bring more uniformity into the CPM examination did not gain enough support, this issue was raised repeatedly in the following years and there was a definite trend towards greater uniformity of teaching and examinations in medical psychology. Possibly, this was a result of the establishment and refinement of the MPA's mental nursing certificate. It was a much larger operation than the CPM, with hundreds of candidates, which required much better administration and, since the same committee oversaw both, it seems likely that they applied some solutions that worked well in one certification programme to another.

Although the MPA established its own certificate, it did not abandon the hope to set standards for compulsory medical education on insanity. In 1893 the GMC revisited its guidance for the medical schools and licensing bodies in the UK. This time they issued a document which was separated into two parts: requirements and recommendations. The requirements stated that all medical students had to register at the beginning of their studies, that the period of study was extended to 5 years, and they provided a list of compulsory subjects, which included mental disease.[33] However, the GMC also noted that:

> It is to be understood, as regards the above-mentioned subjects, that the COUNCIL offers no opinion as to the manner in which the subjects should be combined or distributed for purposes of examination.[34]

There also were no requirements about how the subjects had to be taught apart from five very general recommendations:

I. Attendance of systematic lecture courses — more than 3 a week should not be required
II. Set time aside for practical work
III. Promotion of practical system of clinical teaching — hospital practice with clinical

[33] *GMC Minutes*, 1893: 80
[34] Ibid.

instruction

IV. 5th year should be devoted to clinical work in a public hospital(s)

V. Evidence of clinical instruction in infectious diseases compulsory for qualification in medicine.[35]

In 1893 the GMC also investigated pedagogical practices at all of the licensing bodies and how they complied with their requirements and recommendations.[36] At the same time the MPA Education Committee surveyed how medical students across the country were taught and examined in mental diseases.[37] Both reports concluded that there was an unsatisfying lack of consistency in teaching about insanity at different institutions. The MPA Educational Committee then took it upon itself to produce a syllabus which would be used for the CPM examination and sent it to all bodies examining in medicine, as their recommendation for teaching compulsory courses on mental disease. A sub-committee consisting of Thomas Clouston, George Henry Savage, Conolly Norman and Charles Mercier was appointed to draw up a proposed curriculum with a strict instruction "to keep the requirements down to the minimum of knowledge that should be required of a general practitioner."[38] In this instruction we see that the MPA essentially took the same course of action in compiling their curriculum as the GMC when it was developing the standard for general medical education in 1870s and 1880s. The requirements had to be kept to the minimum necessary for safe practice. Hence, for example, the Educational Committee voted against including any normal psychology into their examination.[39]

In 1894 the Committee issued the first detailed syllabus for the examination for CPM. The exam was to consist of four parts:

1. Written examination where the candidates were required to answer 6 questions in 3 hours. Each examiner was to contribute one question. The Committee made sure that all questions were on unrelated topics. The written portion of the exam was set on the same day in all countries.

---

[35] Ibid: 83.
[36] Ibid: Appendix III.
[37] "MPA Education Committee Minutes 1893–1905", RCPsych, GB 2087 RCPSYCH/G/6, p. 1. Hereafter: *MPA Education Committee 1893–1905*.
[38] Ibid: 5. All four members of the subcommittee were influential alienists who actively participated in MPA affairs. We have already met Thomas Clouston. George Henry Savage (1842–1921) was a medical officer at Bethlem, co-editor of the *JMS* and prolific writer on insanity. Conolly Norman (1853–1908) – was a rising Irish psychiatrists, who, after serving as a superintendent of several smaller institutions, was appointed superintendent of the Richmond District Lunatic Asylum, the largest in Ireland. Charles Mercier (1851–1919) – served as physician at several public and private asylums and was a prolific writer.
[39] Ibid.

2. The *viva voce* interrogation with the use of specimens, drawings and photographs.[40]
3. Clinical examination of a patient with composing a written report on it.
4. Certification of insanity and correction of a faulty certificate.[41]

The fourth part was seen as vitally important as medical practitioners were often sued over mistakes and irregularities in the certificates of insanity.[42]

All of the exam questions had to adhere to the syllabus, drawn by the committee, which included the following subjects:

> I. General symptoms and signs of insanity. Mental Competence. Fitness to be at large.
> II. Causes of insanity
> III. Forms of insanity
> 1) States of weakmindedness:
> a. Idiocy and imbecility
> b. Dementia
> 2) States of Stupor
> 3) States of Depression
> 4) States of Exaltation and Excitement
> 5) States of Delusions and Hallucinations
> 6) Impulsive and "Moral" Insanity
> 7) General paralysis
> IV. Chief accessories of Insanity
> 1) Suicidal tendency
> 2) Homicidal tendency
> 3) Refusal of Food
> 4) Degraded and Perverted Habits
> V. Association of Insanity with Developmental Periods; with the Reproductive Function in its various Phases; with Epilepsies and Convulsive States; and with other Bodily Conditions.
> VI. Morbid Anatomy
> VII. Certification of the Insane and other medico-legal aspects of insanity.[43]

[40] On the visual culture in psychiatry and medical education see education see Rawling 2017, 2021b; Berkovitz 2012; Kemp 1993; Jordanova 1990, 1993; Jackson 1995; Kusukawa 2012; Richardson 2008; Palfreyman and Rabier 2017; Beveridge 2018; Gilman 1988; Danston and Galison 2010; Reinarz 2005.
[41] *MPA Education Committee 1893–1905*: 4–5.
[42] *JMS,* 32 (1887): 529–35.
[43] *MPA Education Committee 1893–1905*: 6–8.

The syllabus was then sent to British medical licensing bodies as "the minimum subjects that candidate for a diploma in medicine should be examined in."[44]

Although in the late 1880s and early 1890s there had been a steady stream of candidates for the CPM, the MPA still struggled with the costs of the examination. It was an expensive endeavour requiring payment for salaries and expenses of the examiners and the registrar (appointed in 1892). Hence it was important to make sure that enough candidates take the exam to at least cover the costs. In 1889, for example, during the discussion of the MPA treasurer's report Clouston urged other superintendents to take an effort to convince their junior medical officers to obtain the CPM, so it would not become a financial burden on the association.[45]

2. The CPM: Failure or Success?

Existing literature on the history of psychiatric education in Britain has considered the CPM as "less than outstandingly successful."[46] By the mid-1900s the MPA members had arrived at a similar conclusion stating that the "special examination and certificate, although successful to a certain point, has fallen far short of the usefulness that was anticipated."[47] From 1900 the exam ran once a year in July, instead of twice as in previous years. In 1905, after numerous attempts to reach the goals set at the time of the certificate's establishment, the MPA Education Committee suggested to discontinue the CPM.[48] It survived past that date on a technicality: its connection to the Gaskell Prize, instituted in 1886, which required all candidates to hold the CPM qualification. Removal of this requirement would necessitate alterations to the original deed to the prize fund — a difficult if not impossible feat of legal work. While the Education Committee in consultation with the MPA solicitors tried to find a way of accomplishing it, they decided to keep the examinations for CPM but with marked lack of enthusiasm.[49] This section will determine what constituted success or failure in relation to the CPM scheme and evaluate its more and less successful features. For that purpose, I will compare the CPM with another educational initiative of the MPA — the Certificate of Proficiency in Mental Nursing, commonly called the Mental Nursing Certificate.[50]

---

[44] Ibid: 8.
[45] *JMS,* 35 (1889): 443.
[46] Bynum 1991: 176. See also Crammer 1996: 220–21; Bewley 2008: 126; Lewis 1967: 115–16.
[47] *JMS*, 54 (1908): 578.
[48] *MPA Education Committee 1893–1905*: 95.
[49] *MPA Education Committee 1905–1924*: 4; *JMS,* 51 (1905): 780.
[50] Surprisingly, the title of this certificate had not been abbreviated in the minutes and articles by historical actors. In the MPA minutes it was often shortened to "nursing certificate" but I will not use this term to avoid confusion.

Although most alienists agreed that good attendants were essential for smooth running of the asylum and provision of adequate care to the patients, until the late nineteenth century they were not considered medical staff. They were usually recruited from the local working-class population: artisans, domestic servants, gardeners, farm-labourers, ex-servicemen and policemen.[51] Attendants' work was onerous, and the salary was not lucrative: on average £8–10 a year, or £12–14 a year at better funded institutions, as for example at the Wakefield asylum during Crichton-Browne's superintendence.[52] Hence, it was often difficult to attract good applicants to such posts and retain them for long. Before the 1880s there had been several initiatives by alienists to change the situation and provide training and financial incentives for asylum staff. For example, Alexander Morison gave a course of lectures to the attendants of the Surrey Asylum in 1843–1844 and founded the Society for Improving the Conditions of the Insane, which had "improving the education and raising the character" of asylum attendants as one of its objectives.[53] The Society granted monetary awards to asylum attendants for "meritorious conduct."[54] In *What Asylums Were, Are, and Ought to Be* W.A.F Browne argued for increasing the salaries of attendants and providing training, so they could advance their skills and knowledge.[55] In the 1850s he delivered lecture courses to the attendants of the Crichton Royal Hospital.[56] His son, James Crichton-Browne was also a proponent of education asylum staff: the attendants and nurses of the West Riding Lunatic Asylum were relatively well-paid and received informal training.[57] He also proposed establishing a school for training asylum nurses on the grounds of the asylum but this plan never came true.[58]

In the 1880s proper training of asylum attendants and nurses transformed from a special interest of some members into a major preoccupation of the alienist community. In 1883, after Campbell Clark (1852–1901), superintendent of Glasgow District Asylum in Bothwell, delivered an enthusiastic paper about his experience of delivering lectures and clinical instruction to the attendants, the MPA established a sub-committee to consider special training for attendants.[59] First, the committee produced the *Handbook for the Instruction of Attendants*

[51] York 2012: 335; Nolan 1996: 177; Monk 2009; Hide 2014: 65–90; Ellis 2001: 235–277. For more history of mental nursing see Neuendorf 2019; Nolan 1993, 1996; McCrae and Nolan 2016; Borsay and Dale 2015; McCrae 2014; T. Dickinson 2015.
[52] York 2012: 335; Nolan 1996: 178; Finn 2012: 74.
[53] Bewley 2008: 111; Scull et al. 1996: 153; "Objects of the Society for Improving the Conditions of the Insane", RCPE, DEP/SOC/2/3.
[54] "Objects of the Society for Improving the Conditions of the Insane", RCPE, DEP/SOC/2/3.
[55] Browne 1837: 165–66.
[56] Bewley 2008: 111–12.
[57] Finn 2012: 73–74.
[58] "Report of the Medical Superintendent", 26 January 1871, WYAS, C85/1/12/3, pp. 29–30.
[59] Clark 1884: 459–66; *JMS,* 30 (1884): 162.

on the Insane — the first textbook for nursing staff at asylums in Britain. The first edition was published in 1885 and the MPA regularly revisited and updated the textbook until its ninth edition, last printed in 1978.[60] Second, in 1889 it developed a programme of training and examination for the Certificate of Proficiency in Mental Nursing.[61] The first exam took place in 1891 and the new qualification was officially established.[62] Unlike the CPM, the Mental Nursing Certificate has been considered a resounding success, by both the MPA members and historians. Let us examine how the programmes have been evaluated.

It is important to note, that the founding of the Mental Nursing Certificate in 1891 was at least in part a consequence of the establishment of the CPM. It built on the experience of creating a curriculum, defining criteria and arranging the examinations that the MPA members gained developing its first professional qualification. In a similar way the CPM was instrumental in creating the arguably more successful postgraduate Diploma in Psychological Medicine in 1911 which I will examine in detail in Section 4. In this way the CPM was an important steppingstone to establishing professional education for British mental health practitioners — both doctors and nurses.

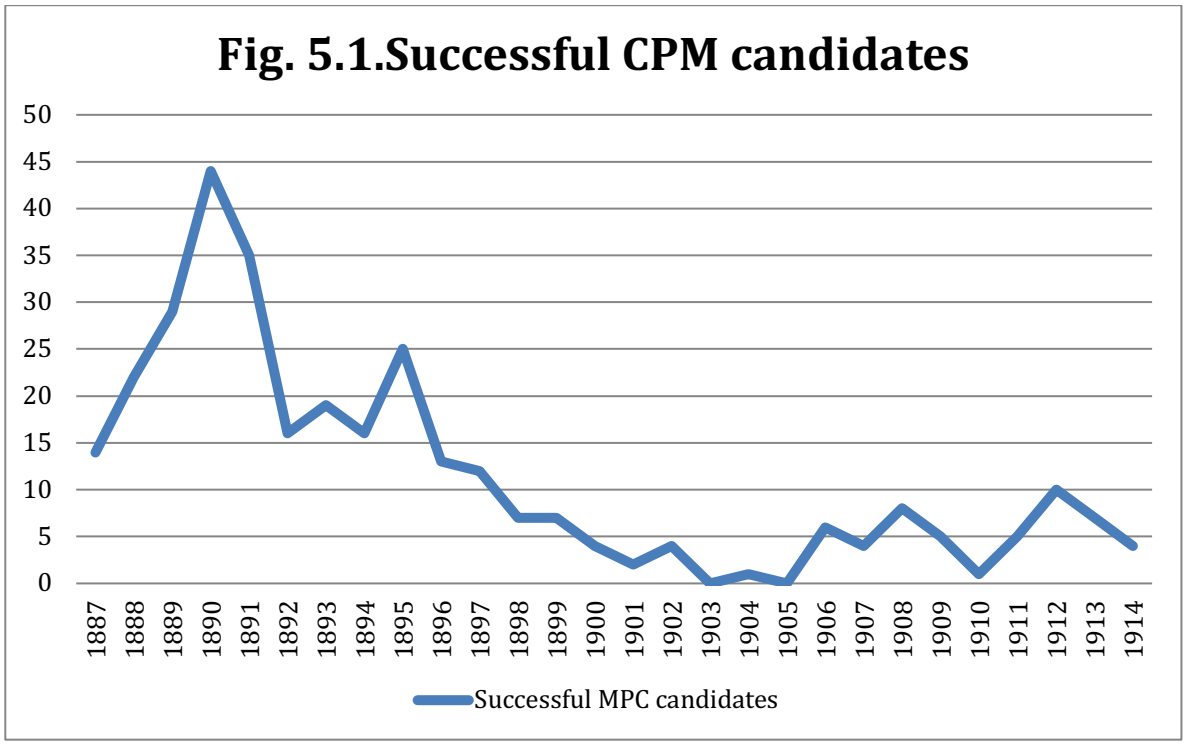
One of the main reasons the CPM was pronounced unsuccessful by the MPA members and historians alike was the fact that the certificate did not attract large numbers of candidates. In the first few years after its establishment it generated a growing amount of interest and the number of successful candidates rose steeply but from the start of the 1890s it began to diminish until no-one received the certificate in 1903 and from then on only a few people certified every year (see Fig. 5.1). The rate of failure for this examination was very low, and most often all the candidates for the certification were successful with just a few years when an occasional failure was reported by the registrar.

In this respect the Mental Nursing Certificate was significantly more successful. Although there were fluctuations between the number of candidates entering for the examination each year, the lowest of the available number of entries never dipped below the count of the first few years and there was a slight but noticeable overall increase in applicants between 1894 and 1910 (see Fig. 5.2). When the MPA switched to a different two-step scheme of examination in 1911 the numbers of applicant remained at least as high as before.

The Mental Nursing Certification also seemed to present more of a challenge to the candidates since the rates of failure were quite high, especially compared to the CPM. The

[60] Bewley 2008: 114; *JMS,* 31 (1885): 149.
[61] *JMS,* 35 (1889): 446–50.
[62] Whitcombe 1891: 501.

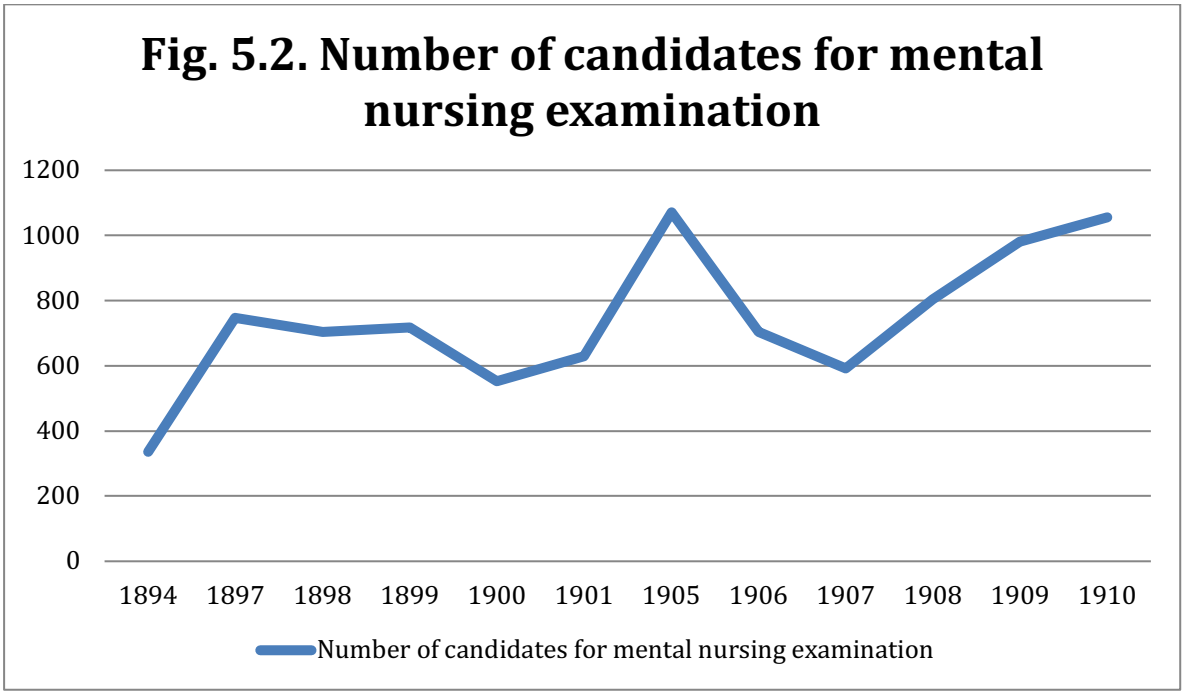
average rate of success for the nursing examination was about 75% with at least one year (1909) when it dipped just below 50% (see Fig. 5.3). The standards for the mental nursing certificate also kept rising with the extension of the required period of training from two to three years in 1905 and the switch to a new examination scheme in 1911 which consisted of two stages — preliminary and final.[63]



Another, less obvious measure of success or failure of the MPA certification schemes was their impact in terms of professionalisation of asylum work and medical treatment of the insane. The CPM did not have the intended impact in that respect. The exam tested the absolute minimum of proficiency in psychological medicine and could easily be passed by a recent graduate or even a medical student. It did not distinguish its holder as possessor of superior knowledge or skills compared to other medical men. The hopes of Thomas Clouston and other MPA members that their certificate would become registrable under the General Medical Council and would become a legal requirement for issuing certificates of insanity or testifying on medico-psychological matters in court did not become reality.[64] However, it is important to recognise that by the 1880s medicine as a whole was already highly professionalised and the growing preference of university degrees over corporate licences meant that most medical men

[63] *JMS*, 51 (1905): 773–79; 56 (1910): 752–76; 57 (1911): 723–46.
[64] *JMS,* 32 (1886): 436.

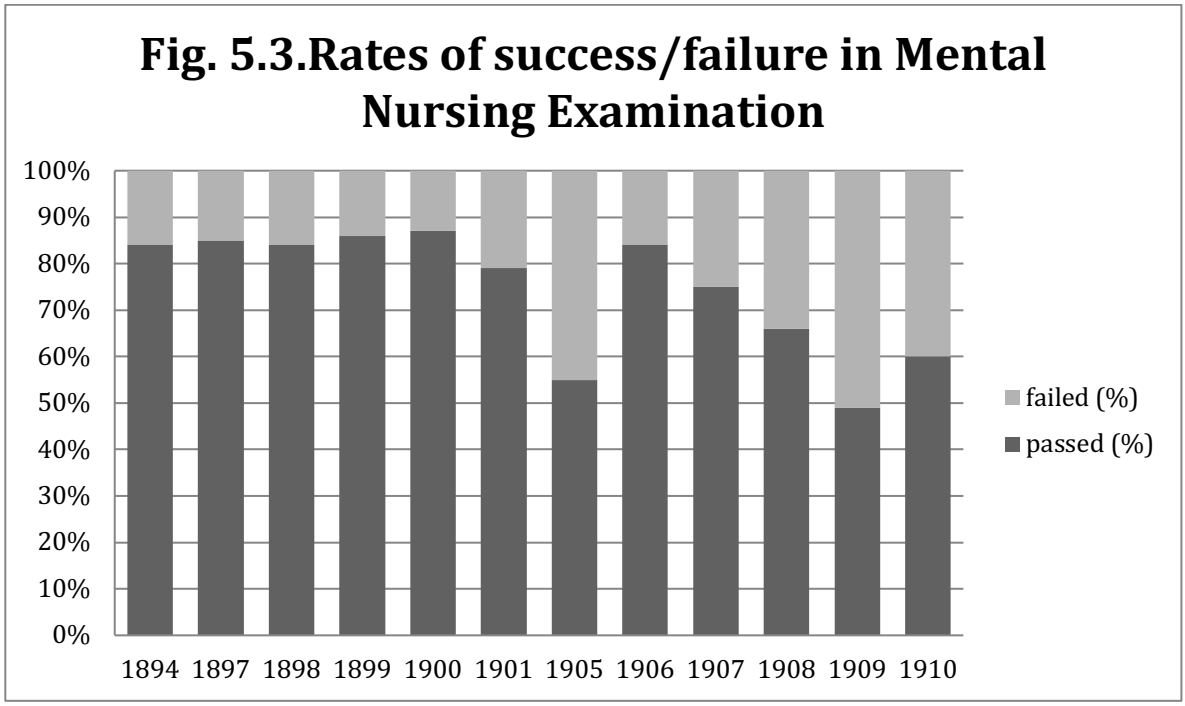
were already recognised as highly educated practitioners.



The Mental Nursing Certificate, on the other hand, helped to create a new professional group and elevate the status of asylum attendants. In the first half of the nineteenth century they were considered uneducated and unskilled labourers who restrained patients, performed routine housekeeping tasks, supervised the work of asylum patients and sometimes dabbled in gardening and other odd jobs on the asylum grounds.[65] However, by the beginning of the twentieth century asylum attendants presented themselves as professional nurses familiar with the basics of human anatomy and physiology, first aid, and tending to physically and mentally afflicted patients.[66] Notably, the professionalisation of mental nurses was happening alongside the professionalisation of general nursing in Britain, and in this respect, again, asylum medicine followed the main trends of general medicine.[67] When the hospitals, workhouse infirmaries and other medical institutions switched to employing professional nurses, the asylums soon followed. There had been attempts to merge the different nursing qualifications or publish the register with different categories but in 1895 asylum attendants were rejected from the Royal British Nurses' Association and had to organise their own professional structure. They did this with the help of the MPA, which facilitated the foundation of the Asylum Workers Association

[65] See for example *JMS,* 7 (1861): 316–17; Nolan 1996, 1993; York 2012: 335; Monk 2009.
[66] Neuendorf 2019, Nolan 1996.
[67] Cohen 2019.

in 1895 and its periodical the *Asylum News.*[68] Hence, special training and certification increased the professionalisation of asylum attendants and fostered their collective identity, which became independent of the MPA later in the twentieth century.[69]



Finally, there was one more failed expectation related to the establishment of CPM — that it would encourage new medical practitioners at large and junior asylum medical officers in particular to engage in scientific research and further study of medical psychology. Although there was some research activity on medical psychology and neurology at asylums, neurological hospitals and medical schools none of them seem to be in any way related to the CPM which did not require engagement in original research. The scarcity of entries for the MPA Bronze Medal and the examinations for the Gaskell Prize also suggest that the CPM holders and asylum medical staff were not especially interested in conducting their own research.

Considering the above, the disappointment of MPA members and historians in the CPM scheme appears reasonable. It did not function in the way its creators intended and did not bring the results they anticipated. However, it was a crucial step in the development of the MPA as an educational and certifying authority.

[68] Neuendorf 2019; McCrae & Wright 2016; Nolan 1993.
[69] Neuendorf 2019; McCrae and Wright 2016; McCrae 2014.

3. The MPA's Conservative Approach to Education

Historian William Bynum suggested that one of the main reasons for the CPM's failure was the MPA's success at introducing psychological medicine into the compulsory undergraduate medical curriculum, which made the CPM superfluous.[70] Although I agree with this statement in principle, I think it needs further analysis. As discussed earlier in the chapter, one of the rationales behind establishing the MPA's own qualification, indeed, was to create an alternative plan of teaching medical practitioners about insanity in case their campaign to the GMC failed. However, the MPA learned about the GMC's positive decision early on and decided to continue developing their own certificate anyway. The creation of CPM pursued multiple other goals and evidently fell short of them. This failure is especially striking compared with the success of the Mental Nursing Certificate. In this section I will discuss the reasons why the CPM did not become a popular postgraduate qualification.

First of all, even though Bynum's suggestion did not explain all of the problems with the CPM, it definitely identified one of them. The CPM curriculum deliberately included only "the minimum subjects that candidate[s] for a diploma in medicine should be examined in."[71] The same curriculum was sent to all of the UK licensing bodies as a standard for undergraduate instruction in mental disease. Although the licensing bodies did not have to comply with the MPA's suggestion, it is important to remember that most teachers of medical psychology were members of the association and were likely to adopt the recommended course. Hence, in practice, the main difference between recent medical graduates who passed the CPM and those who did not was the availability of three spare guineas for the examination fee and one more exam on the subject all medical students were required to study. The level of training, knowledge and practical skills of the medical practitioner would be the same with or without the CPM. It was evident from Clouston's admission that he counted his undergraduate students' exam papers on mental disease as the written part of the CPM exam.[72]

Moreover, there was no clear professional benefit of acquiring the CPM apart from proving that the holder paid attention during their compulsory classes and retained the knowledge well. The GMC regulations required that all medical students received instruction on mental disease, but it did not oblige them to take an exam on the subject. As Edmund Whitcombe, an asylum superintendent and a teacher of medical psychology in Birmingham,

---

[70] Bynum 1991: 176.
[71] *MPA Education Committee 1893–1905*: 8.
[72] *JMS*, 37 (1891): 650.

put it at the MPA meeting in 1888 "[m]edical men who had just got their diplomas were not fond of going in for examinations – considered that they had been examined enough."[73] If they were to put themselves through another ordeal they needed to be convinced that it would provide an advantage for their career. Unfortunately, the MPA could not guarantee such an advantage because it did not control the job market for asylum medical officers.[74] They were appointed by asylum governing boards which consulted the superintendent but were empowered to make their own decision. These committees did not consider the CPM an important sign of distinction when making decisions about hiring or promoting medical staff at the institutions under their care. Moreover, some MPA members suspected that that many senior alienists were not in favour of giving hiring preference to the CPM holders and of their junior medical officers taking the exam. A cynical commentator explained it by saying that "many superintendents were not fond of experts as assistants; they were content to be experts themselves."[75] A more generous way of understanding some superintendents' reservations about the CPM was to consider how it could upset the hierarchy in the institution. Ideally, an appointment should be given to a candidate who had more knowledge, skills and/or experience than others, but the CPM did not guarantee either since it only tested the bare minimum of required knowledge and was a "pass examination", so it did not distinguish between different levels of proficiency. Moreover, some asylum doctors saw the CPM becoming a requirement for asylum appointments or promotions as a threat to their own positions. Older medical officers did not fancy recent graduates with a certificate being promoted over them.[76]

The crucial importance of improved career prospects for making certification more popular becomes evident if the CPM is compared to the Mental Nursing Certificate. Asylum superintendents had full control over hiring attendants or nurses for their institutions and provided incentives for certified mental nurses in the form of salary raises, preferential hiring and promotions. A mental nursing certificate also made it easier for asylum nurses to go into private practice.[77] This accounted for a steady stream of applicants for the certificate.

Another reason for the CPM's lack of success as a postgraduate qualification was the fact that it was a vocational rather than academic qualification.[78] The exam tested text-book knowledge and basic skills. It did not require independent research or additional academic

[73] *JMS*, 34 (1888): 454.
[74] *JMS,* 36 (1890): 43–50; Thomson 1908. For a detailed analysis of the politics of lunacy and the balance of power at the time, see Ellis 2020.
[75] *JMS*, 34 (1888): 454.
[76] Ibid.
[77] *JMS,* 50 (1904): 790.
[78] Clouston 1911: 214.

study.[79] The extremely high pass rate of the CPM examinations suggested that they were not particularly challenging. The qualification was postgraduate only in a sense that the certificate could only be issued to a registered medical practitioner, but it was often taken by undergraduate students at the end of their university course.[80] Thus, it tested knowledge gained during undergraduate studies and not additional expertise. Also, the CPM had no legal power and did not become a registrable qualification as some of its creators hoped. The reformed lunacy legislation of 1890 did not rule that any special training on mental disease was required to diagnose and treat insanity or to testify on it in court.

The MPA Education Committee noticed that their certificate struggled to attract candidates and made several attempts to revive it. However, none of them significantly improved the situation because the measures they adopted did not address the real problems underlying the CPM's lack of success.

First, the committee made the certification requirements as easy as possible and kept them this way. The reasoning behind it was that a low bar would be easier to clear for a larger number of candidates who would be attracted by the high chance of success at a first attempt.[81] However, as we have already seen the easiness of the requirements devalued the qualification scheme. The examples of the MPA's Mental Nursing Certificate demonstrated that with clear career advantages and a chance to meaningfully improve one's level of qualification a certification scheme could remain popular regardless of the high failure rate and increasing difficulty of training. On the contrary, the difficulty imbued it with more value both in the view of employers and the candidates themselves.

Secondly, the Education Committee attempted to make taking the CPM exam more convenient. Initially, the examinations took place in London, Edinburgh and Dublin, but eventually more opportunities were organised in larger cities in Scotland and Ireland. Exams for England always happened in London. In the early 1900s it was proposed that the candidates should be able complete a written part of the exam at the place of their training and only travel to a different location for the *viva voce*.[82] Although having to travel long distances to pass an examination was a considerable hurdle for some junior medical officers at asylums, it would not be insurmountable given a good incentive. In the absence of one, most practitioners did not attempt to qualify for the CPM even if it was conducted at a convenient location.

---

[79] Ibid.
[80] *MPA Education Committee 1905–1924*: 48.
[81] Ibid: 46–48.
[82] Ibid: 49.

When advertising the CPM to medical students and general practitioners, the MPA members stressed the reasons why proficiency in treating mental diseases was important to all medical men.[83] Evidently, they hoped to appeal to the largest possible audience. However, this approach made their reasoning vague and unexciting. It did not capture the imaginations of large medical audiences because, again, there were no clear career incentives to obtain the CPM and no intellectual, academic or research challenges to make the qualification a real achievement. It was useless for the general medical practitioners and not advanced and interesting enough for the people who wanted to specialise in mental diseases.

It is not surprising that these feeble attempts to remedy the situation did not work. Clearly, the MPA misjudged the situation profoundly. There were several reasons for this. First, from the beginning of the nineteenth century one of the main goals of the alienists' community was to convince the medical establishment that mental disease was a part of general medicine and not a specialism. From its inception, the MPA, on behalf of all British alienists resisted specialisation of medicine, contrived to emphasise the links between medical psychology and general medicine, and downplayed the aspects of asylum practice which distinguished it from other medical occupations. For decades it helped psychiatry to claim a place within the British medical profession and connect with the medical elites. As demonstrated in the previous chapter, the same tactic proved effective in achieving compulsory instruction in mental disease in 1885 and in securing posts for teachers of medical psychology at medical schools across the country. However, at the end of the nineteenth century when the tide of medical opinion turned towards the acceptance of medical specialisation and specialised training, the inertia of the previous decades did not allow the MPA to quickly capitalise on that trend.[84] Instead of creating a demanding postgraduate programme for those with a special interest in mental disease it attempted to create a certificate which would suit the most general medical audience.

Furthermore, by the second half of the nineteenth century the MPA became a very conservative body. To a large extent that was also the result of its struggle for acceptance within the system of British medicine. Having constantly been cast in a role of an outsider discipline based on practice in remote asylums, whenever possible British medical psychology tried to demonstrate the most conservative and traditional views in order to prove that it did not threaten the existing professional structure. Hence, the MPA struggled to connect with the younger, less

[83] Ibid: 56.
[84] Weisz 2003; 2006.

orthodox practitioners: it did not know their needs and could not address them.

A typical example of the MPA's conservative attitudes was its resistance to women in medicine. In Britain women were officially allowed to qualify in medicine from 1876 and, although there was significant pushback against allowing them entrance into the profession from the 1880s they were gradually admitted to medical schools, licensing examinations and medical associations.[85] However, it took until 1894 for the first woman to be allowed to join the MPA, against significant resistance, even though the CPM had first been granted to a woman, Jane Elizabeth Waterston (1843–1932), in 1888. Unfortunately, there is very little information about the reasons Waterston decided to acquire the qualification. However, there was a clear reason why she was allowed to do so without any impediments. In the 1860s Waterston went to Africa to work as a missionary. From then on she returned to Britain twice: in the 1870s to join the first cohort of the London School of Medicine for Women and qualify in medicine, and then in the late 1880s when she travelled to Europe to receive her doctorate (in Brussels), become a licentiate of the Royal College of Surgeons and take examination for the CPM.[86] She had no intention of staying in Britain, joining the MPA or attending any of their meetings. That was a woman the MPA could deal with: she paid her fee, appeared at the exam and promptly went away without imposing her unbearable femaleness on the members of the association. After that several more women with a similar unobtrusive attitude obtained the CPM.

When it came to admitting women into the association and possibly having to suffer their presence at the meetings, the MPA members were not as nonchalant about it. In 1871 the issue of women appeared in the MPA minutes for the first time: it was mentioned in passing and quickly dismissed without discussion.[87] The question rose again in 1893 when Conolly Norman, a superintendent of the Richmond District Asylum, Dublin, nominated one of his clinical assistants — Eleonora Fleury (1867–1960), MB, B.Ch. Royal University of Ireland.[88] According to historian Laura Kelly, Irish universities and medical institutions were more accepting of medical women than British ones and by the 1890s there were a significant number of qualified women-practitioners, many of whom worked in asylums for various periods of time.[89] Fleury was very successful academically, graduated school first in her class in 1887 and

[85] Blake 1990; Bonner 1992: 120–37.
[86] Heyningen 1996.
[87] *JMS,* 17 (1871): 446.
[88] *JMS,* 39 (1893): 598.
[89] Kelly 2012; 2017: 170–99.

was awarded a Gold Medal with her MD degree at the Royal University of Ireland in 1890.[90] She worked at the Richmond District Asylum under the superintendence of Conolly Norman, who apparently had a sufficiently high regard for her to nominate her for the membership at the MPA.[91]

The appearance of Fleury's name on the list of member nominees in 1893 caused embarrassment and discontent amongst the older more conservative members. At the time the procedure for the election of new members consisted of voting for the whole list of nominees and, if there were voices against, conducting a vote on each nominee separately. At first Norman was accused of trying to trick the members into accepting a woman against the rules of the association and creating a precedent.[92] When he explained that he took the phrase "medical men" in the rules of eligibility to mean "medical practitioners" and to cover both men and women, several members were even more shocked. Mercier compared the attempt to include a duly qualified woman into the association to an attempt to extend membership to a convict.[93] None of Norman's arguments that women were already admitted into the profession, or that many of the members taught women in their classes at universities or employed them at asylums convinced the meeting to accept Eleonora Fleury, and the issue was postponed to the next year's meeting to allow members more time to consider the repercussions of allowing women to join.[94] Fleury's nomination was approved by the majority of the votes in 1894 but she never attended the annual MPA meetings in person.[95] A few more women joined after 1894 but, according to the existing minutes, they also rarely came to the meetings and mostly chose to stay silent.[96]

The discussion about women took place at a time when the MPA struggled to attract candidates for the CPM examination and worthy applicants for junior medical officer posts at lunatic asylums. These two problems were frequently discussed at the meetings and in the medical press between the 1880s and 1910s, but the MPA did not even consider that inviting women to join the association and encouraging them to qualify for the CPM could help with their problems. The MPA could have benefitted from their fees, determination and high academic achievements, if it chose to do so, especially considering that women still

[90] Kelly 2012*:* 87; Collins 2013.
[91] Collins 2013; O'Shea and Falvey 1996: 422.
[92] *JMS,* 39 (1893): 598.
[93] Ibid: 599.
[94] Ibid: 599–600.
[95] *JMS,* 40 (1894): 691; O'Shea and Falvey 1996: 422.
[96] For more on women-medical officers at English asylums see Hide 2014. For women in British medicine see Almond 2021; Blake 1990; Bonner 1992; Haynes 2017. For women in Irish medicine see Kelly 2012.

encountered resentment at their presence at medical schools and struggled to find positions at hospitals to fulfil the clinical requirements for medical registration.[97] The example of Irish medical schools and asylums demonstrated that, if offered opportunities for instruction and work, women frequently took them, thus, it would have been likely that they would do the same in the rest of the UK.[98] The MPA took a similarly rigid and conservative stance on a number of issues, such as medical specialisation and acceptance of new approaches, for example being slow to accept Kraepelin's clinical psychiatry or psychological theories of mental illness.[99]

Finally, an important factor in the CPM's failure was the decline of the system of lunatic asylums. On the verge of the twentieth century lunatic asylums swelled to grotesque sizes, often housing over 1000 patients, most of them "chronic" who would stay there indefinitely.[100] However, the increase in numbers of institutionalised insane did not cause a correspondingly high demand for asylum medical officers or increase in their salaries. The relentless pressure to save funds meant that in most large public asylums each medical officer was responsible for hundreds of patients.[101] In addition to this, each asylum had only one superintendent and there were relatively few new institutions opening in this period, meaning that there were few opportunities for promotion to the superintendent's position. Other asylum medical posts came with significantly smaller salaries and uncomfortable social restrictions.[102] For example, assistant medical officers were not allowed to get married since they had to reside on the asylum grounds and there were no provisions for family accommodation. All of the above made medical careers in lunatic asylums unattractive and the CPM had almost no professional recognition outside of the asylums. Therefore, the interest in the certificate was very limited and almost disappeared as soon as all the medical officers of asylums where the CPM was encouraged acquired the qualification.

4. Openly Specialised Training: Diploma in Psychological Medicine

By 1905 it had become clear to the MPA that the CPM was not salvageable. The education Committee voted to discontinue the examinations though the decision was not

[97] Blake 1990: 156–92; Bonner 1992: 120–37; Almond 2021: 28–68.
[98] Kelly 2012. Louise Hide's work on London asylums also demonstrates that women wanted to work as asylum medical officers (2014).
[99] Ion and Beer 2002a, 2002b; Pines 1991; Clark 1981.
[100] Scull 1993: 267–333.
[101] Scull 1993: 310–15; Ellis 2020; Takabayashi 2017.
[102] Thomson 1908*; JMS,* 36 (1890): 43–50; 76–77; 60 (1914): 667–74; 683–85; Bedford Pierce 1912; Orr 1912; Hide 2014: 40–65.

enacted right away only because of the entanglement of the certificate with the Gaskell prize.[103] The scheme continued for another decade, but the association ceased active attempts to promote or improve it. However, in the early twentieth century the growing acceptance of medical specialisation in Britain led to the need for regulation and standardisation of specialist practice.[104] Hence, there was increasing demand for specialised training and certification. By the turn of the century there had already been established two medical postgraduate certificates in public health and tropical diseases and in the 1900s other less formal programmes proliferated.[105] It did not take long for the MPA members to engage in designing a new postgraduate qualification in medical psychology — the Diploma in Psychological Medicine (DPM). This was a more successful endeavour than the CPM, and it addressed most of the problems of the previous certificate. This section will discuss the establishment of the DPM and its main advantages.

The MPA was spurred into action in 1908 by Henry Maudsley's endowment of £30,000 to the London County Council for the establishment of hospitals for mental diseases for

> (1) the early treatment of cases of acute mental disorder, with the view, so far as possible, to prevent the necessity of sending them to the county asylums; (2) to promote exact scientific research into the causes and pathology of insanity, with the hope that much may yet be done for its prevention and successful treatment; and (3) to serve as an educational institution in which medical students might obtain good clinical instruction.[106]

David Thomson, the superintendent of the Norfolk County Asylum, seized on Maudsley's address as a prompt to raise the issue of postgraduate training in psychiatry. He presented a paper on the subject at the MPA's quarterly meeting in London on 19 May 1908.[107] Thomson claimed that "a smattering or merely the elements of any of the subjects taught in medical curriculum is attainable" during undergraduate studies, because the medical curriculum was already overcrowded and the minds of the students were unprepared for more complex subjects.[108] Thus, Thomson concluded that "Dr. Maudsley rather aims […] at the education in psychiatry […] of the post-graduate medical student who desires to take up mental disease as a specialty or as an adjunct to the practice of pure medicine or neurology."[109] He then launched

[103] *JMS,* 51 (1905): 780.
[104] Weisz 2006: 87–104; 164–90.
[105] Weisz 2006: 167; Hanley 2015; Thomson 1908: 552; 1910: 1247.
[106] *Lancet*, 171 (1908): 728; Allderidge 1991.
[107] Thomson 1908.
[108] Ibid: 552.
[109] Ibid.

into the details of his proposed programme for a postgraduate course on mental diseases. First of all, he noted that clerkships and junior positions at the asylum could not be considered as proper postgraduate instruction because "the medical superintendent is in many instances unqualified, even if he had the time, or were it his duty to do so, to give or direct the necessary training and teaching."[110] Therefore, according to Thomson, the new course had to be hosted by the universities or other medical teaching bodies and to grant official diplomas.[111] These diplomas, he argued, should become compulsory to take a position within the lunacy system. Secondly, it was necessary to make postgraduate training substantial and rigorous: the programme would take one or two years to complete, cover academic subjects adjacent to clinical psychiatry (for example, physiology of the nervous system, neuropathology and experimental psychology) and require the student to produce their own research.[112]

The discussion which followed Thomson's paper revealed how profoundly the alienists' attitudes to education had changed compared to the mid-nineteenth century. First of all, no-one objected to specialist postgraduate training, quite the opposite: the minutes showed that Thomson's suggestion in general had the support of everyone at the meeting. There had been some dissent, but it related only to particular details. Secondly, everyone at the meeting agreed that the programme of training must provide firm grounding "not only in the most advanced, but in the more elementary and preparatory study, so that [it gave] a firm grasp of the whole" subject.[113] Instead of trying to reduce the curriculum to a bare minimum Thomson and his colleagues proposed to make the postgraduate course as comprehensive and systematic as possible. Finally, there was no doubt about the need to learn about normal psychology: "[i]f insanity was, as it was always called, a disease of the mind, […] surely persons who studied it and were constantly immersed in the treatment of it ought to know something about the normal mind before studying the abnormal mind."[114] There was some discussion about the exact subjects which needed to be included in the curriculum, the extent of involvement of asylums and senior asylum staff in instruction for the diploma, and the relative weight of academic study, clinical work and research. The meeting ended with the decision to forward the issue for to the Education Committee for the development of a draft scheme and return to the discussion at the annual meeting.[115]

---

[110] Ibid: 553.
[111] Ibid: 554.
[112] Ibid: 554–55.
[113] Ibid: 557.
[114] Ibid.
[115] Ibid: 559.

The idea of establishing postgraduate training along the lines suggested by Thomson met with enthusiastic support from the MPA members and large sections of the British medical community. While the Education Committee was working on producing a programme of study and approaching university medical schools for collaboration, Thomson promoted the scheme at the BMA meeting (the proceedings were published in the *BMJ* and the *Lancet*) and even during the BAAS conference in 1912.[116] The response was largely positive and in 1911 four British universities launched DPM programmes: Edinburgh, Leeds, Manchester and Durham.[117] In 1912 they were joined by the University of Cambridge.[118] It was an important advantage of the DPM, compared to the CPM, that it was connected to the universities, rather than to the MPA. By the end of the nineteenth century universities began to play the leading role in medical education as they could provide scientific and laboratory training and carried out most medical research.[119] Consequently, the university degrees and certificates awarded their holders more respect and recognition than non-academic certificates.

The one licensing body which reacted negatively to the proposal of the DPM was the Royal College of Physicians in London. Having received a communication from the MPA, which proposed the establishment of postgraduate instruction in psychiatry, the RCP called an extraordinary meeting to discuss it.[120] Four members spoke in favour of the proposal: Charles Mercier, Robert Percy Smith, Thomas Claye Shaw and Bedford Pierce. All four of them were also prominent alienists and members of the MPA. Three members spoke against: Richard Douglas Powell, Norman Moore and William Selby Church. All of them celebrated physicians, politically conservative, born in the 1840s and qualified in the 1860s and 1870s, at the time when the resistance to medical specialisation was the most vehement.[121] Their arguments echoed the discourse of those mid-century debates. Powell warned against establishing specialist teaching, saying that "there was a danger in a course of that kind of losing touch with general medicine, so that the problem might easily arise as to where such propositions might end."[122] Norman Moore argued that all necessary knowledge should be included in the compulsory curriculum. If it was not necessary but simply desirable, it should be left to the practitioners to learn voluntarily. He was especially concerned about the suggestion to make a

[116] Thompson 1910; *Lancet,* 176 (1910): 830–31; *BMJ*, 2 (1912): 724.
[117] Clouston 1911; Orr 1912; *BMJ,* 1 (1910): 1447–48; *Lancet,* 178 (1911): 1301, 1520; *JMS,* 59 (1913): 159–61, 167–77.
[118] *BMJ,* 1 (1911): 350; *Lancet,* 180 (1912): 1670; Orr 1912.
[119] Bonner 1995: 280–308; Bynum 1994.
[120] *Lancet, 175* (1910): 729–31.
[121] *DNB.*
[122] *Lancet, 175* (1910): 729.

postgraduate diploma in psychiatry compulsory for asylum service because it would bar qualified practitioners from the employment they should be entitled to by their medical qualification alone.[123] Church saw in the proposal to establish postgraduate qualification in psychiatry a suggestion that the current medical curriculum was not executed well and that the existing licenses did not guarantee that the students possessed the necessary knowledge.[124] All of the arguments against the DPM reflected the stance of the nineteenth-century medical elites on the issue of specialisation: medical men were allowed to have special interests but there should be no overt recognition of specialisms.[125]

At the RCP the matter was forwarded to a special committee, which decided against instituting a diploma in psychiatry. Instead, it offered all RCP members an opportunity to present themselves for a special examination in psychological medicine and, if they were successful, receive a certificate testifying to their knowledge.[126] The examination covered the following topics: psychology, the study of conduct in relation to mental disorder, psychological medicine and jurisprudence in insanity. The examination consisted of a written paper, *viva voce* and performance of clinical duties in an asylum. This scheme bore a striking resemblance to the CPM and was not very successful for the same reasons. The only real advantage it offered, compared to the MPA certificate, was the authority of any certificate granted by the RCP.

The DPM, on the other hand, faired significantly better, than both the CPM and the RCP certificate. When designing it the MPA Education Committee took into account the flaws of the previous certificate and attempted to remedy them. First of all, the DPM was conceived as a truly specialist qualification: it was not supposed to interest all medical practitioners, but on the contrary, its intended target audience were current junior asylum officers and practitioners who aimed to establish a career in psychiatry.

Although the MPA did not have the power to make this qualification compulsory for employment in asylums, it took pains to make it meaningful. The design was for a comprehensive and rigorous programme of training which went far beyond the standard undergraduate course. To be eligible for the DPM programme the candidate had to be a fully registered medical practitioner of no less than two years and have spent at least 12 months as a full-time medical officer or a clinical assistant at an asylum.

---

[123] Ibid: 730–31.
[124] Ibid: 731.
[125] Weisz 2003: 561–74; 2006: 26–43; Casper and Welsh, 2016.
[126] *Lancet,* 177 (1911): 395; *BMJ,* 2 (1911): 318.

The DPM required attendance at advanced courses of practical instruction on several subjects:

(a) Neurology: the anatomy, physiology, and pathology of the nervous system
(b) Psychology.
(c) Clinical pathology.
(d) Clinical neurology.
(e) Psychiatry, lectures and demonstrations on, and the jurisprudence of psychiatry.
And on one of the following five optional subjects:
(a) Advanced psychology.
(b) Bio-chemistry.
(c) Bacteriology.
(d) Comparative anatomy and physiology of the nervous system.
(e) Eugenics.[127]

Each of these subjects had to be studied over approximately three academic sessions of three months each. The Education Committee considered neurology crucially important for understanding other subjects and required that at least a third of the time of study had to be devoted to that subject.[128] Furthermore, the MPA went to great lengths to obtain the opinion of assistant medical officers of asylums on the subject of the new qualification.[129] They considered what would make the programme more attractive to them and what would make their posts within the asylum system desirable for talented and scientifically minded practitioners. These consultations revealed a very complex tangle of issues, and it became obvious that unless the position of junior medical officers were sufficiently improved, they would not have the time, funds or inclination to participate in a long and demanding postgraduate programme.[130] Hence, the MPA's attempts to introduce rigorous postgraduate training combined with further efforts to reform the whole system of asylums and psychiatric services in Britain. In addition to establishing the diploma courses at various universities, the MPA thus started an active campaign for opening outpatient clinics as centres for treatment of acute insanity, for research and teaching of psychiatry, and for employment of psychiatrists.[131] This movement was largely inspired by the system of psychiatric training in Germany, where

[127] *JMS*, 56 (1910): 375.
[128] Ibid.
[129] *JMS,* 59 (1913): 688–92; 60 *(*1914): 667–74.
[130] Orr 1912; Bedford Pierce 1912; *JMS,* 59 (1913): 688–92; 60 *(*1914): 667–74; 683–85.
[131] *JMS,* 60 (1914): 669–74; Thomson 1908; Rows 1912; *Lancet,* 179 (1912): 934–35; 1089–90.

postgraduate students received systematic lectures, performed clinical duties and conducted laboratory and clinical research at the special psychiatric units attached to universities.[132] Unlike in the British asylums, German postgraduate psychiatry students enjoyed the advantages of having a community of peers with whom they could discuss recent advancements in the field, present their own research and collaborate on projects.[133] The suggested outpatient clinics were expected to offer the same advantages to British psychiatrists. At the same time the MPA launched a campaign for improving the position of junior medical officers in asylums: increasing their salaries, lessening social restrictions, providing leave to attend university courses for the diploma and finding dedicated time for research and self-education of asylum officers.[134]

Conclusion

At the turn of the century the approach of the British medical community to specialisation changed from resistance to gradual acceptance and attempts at regulation. Surprisingly, although in many respects medical psychology had already become a distinct specialism, it struggled with presenting itself as such and developing specialist postgraduate training in mental disease. The first certification programme developed by the MPA in 1887, the CPM, was so similar to the compulsory instruction received by all medical students at the time that it did not offer enough of an incentive for medical practitioners to take part. However, the following qualification schemes established by the MPA were considerably more successful. The Mental Nursing Certificate founded in the 1890s attracted hundreds of candidates every year and significantly contributed to professionalisation of mental nurses in Britain. The DPM, launched in 1911, attracted enthusiastic support from large segments of the medical community and became the first proper British postgraduate qualification in psychiatry.

The CPM's lack of success was not due to the incompetence of the MPA in organising training, nor was it a result of low demand for psychiatric knowledge. To a large extent the failure was caused by the conservatism of the MPA which for most of the nineteenth century was exerting considerable efforts to make medical psychology appear part of general medicine and deny its specialist characteristics. This strategy worked well in the past and helped British alienists establish compulsory training on their subject and gain places in medical elites,

[132] *JMS,* 60 (1914): 674–81; *Lancet,* 179 (1912): 1017–18.
[133] For an overview of German psychiatric training see Engstrom 2004: 147–173.
[134] *JMS,* 60 (1914): 671–74; 682–85.

therefore it was not surprising that it took the MPA some time to adjust their tactics to the new situation.

When the question of postgraduate psychiatric training rose again in 1908 the MPA members adopted a different approach. They learned from their previous mistakes and designed a rigorous and comprehensive programme of study connected to university medical schools. The MPA also took into consideration the needs of junior medical officers in lunatic asylums and attempted to address them through the DPM programme and a campaign to improve their employment conditions, taking inspiration from foreign training in psychiatry, especially the German system.

Conclusion: Building the Discipline of Psychiatry through Education

In this thesis we traced the main phases in the development of psychiatric education in Britain over the long nineteenth century. Having started with an unaffiliated course taught by a physician looking to establish a stable source of income for himself, by the end of the period instruction on mental disease had become a part of the compulsory medical curriculum taught nationwide and one of the subjects for emerging postgraduate medical qualifications. Through all its transformations psychiatric education was deeply connected to the changes in British psychiatry, the medical profession and society at large. Throughout the period improving medico-psychological training was an important part of the agenda of British alienists: it was seen as a way to ensure better care for the insane, to strengthen the authority and reputation of asylum doctors in the eyes of medical and lay publics, to advance research on mental disease and to attract more talented recruits to the field. This history explains Thomas Clouston's words about educational advancements which opened the introduction to the thesis. It becomes clear why Clouston and numerous other nineteenth-century psychiatrists regarded advancements in education as being amongst the most important events for the development of their specialism.[1] In this conclusion I will briefly summarise the main findings of the thesis, outline how my work contributes to the larger historiography and propose possible directions for future research.

In Chapter 1, I demonstrated that demand for education on mental disease appeared with the establishment of the first lunatic asylums on the eve of the nineteenth century. Following the prevailing entrepreneurial style of medical education of the time, the first course on insanity took the form of a private extra-institutional lecture series. To finance his grand scheme Alexander Morison, the author of the lecture course, asked his wealthy patients and acquaintances for donations, found a rich patroness and appealed to famous medical practitioners and aristocrats for endorsements. Although it was not especially popular, the course ran for 21 years in Edinburgh (1823–1844) and 19 years in London (1825–1844). It brought Morison an income from well-invested initial subscriptions, fame and status as a teacher and specialist on mental problems, and a particular kind of clientele — wealthy mentally ill patients and their families who would not go to a public asylum and did not want to attract attention to their condition. Even more importantly, it put mental disease on the map

[1] Clouston 1911: 207.

of medical knowledge as a distinct subject of study for medical students and practitioners.

Fundamental changes in print culture in the early nineteenth century created further opportunities for acquiring knowledge on mental disease. Commercial publishers and entrepreneurial authors took advantage of the demand for medico-psychological knowledge and produced a wide array of literature on the subject. Publications on insanity frequently appeared in medical periodicals – a genre of literature which grew rapidly at the start of the century. The fast-paced medical weeklies, like the *Lancet* and *London Medical Gazette*, often published transcripts of lectures on mental disease, anatomy and physiology of the nervous system and forensic medical psychology which were especially useful as educational materials. As medical education at the time was largely unregulated and disorganised medical students and practitioners were used to taking responsibility for their training and were skilled at supplementing more formal instruction with printed materials. They used the publications on mental disease to learn and stay up to date with the changes in the field.

In the 1840s and 1850s the asylum system entered its golden age with the lunacy legislation of 1845 compelling all counties to build rate-supported asylums. The erection of new institutions and their subsequent rapid growth created employment opportunities for trained alienists. Hence, the demand for education on insanity grew accordingly. At the same time medicine as a whole was undergoing a period of intensive professionalisation, which inevitably affected asylum doctors as much as any other medical practitioners. Following general professional trends, British alienists established their own association — the Association for Medical Officers of Asylums and Hospitals for the Insane — which still exists today under the name of the Royal College of Psychiatrists. They also launched a journal to share knowledge and promote discussion within their field. It was initially called the *Asylum Journal of Mental Science* and underwent several title changes before settling on the current *British Journal of Psychiatry*.

A tenacious twenty-year-long campaign for medical reform resulted in the passing of the 1858 Medical Act, which standardised and formalised the structure of the medical profession and created a special body to oversee all medical matters — the General Medical Council. As I demonstrated in Chapter 2, alienists, together with the rest of the British medical community, were deeply involved with the reform movement and concerned with its outcome. The issues of medical education and its improvement constituted a large part of the disputes surrounding reform. It was widely acknowledged that professionalisation was impossible without a consistent system of instruction. The members of the AMOAHI applied this reasoning to their discipline and strove to implement the most advanced contemporary ways of

training in their field — clinical instruction in patient wards. John Conolly's course at the Middlesex Lunatic Asylum in Hanwell was a pioneering example of this kind of teaching, with other courses cropping up in different parts of the country. However, these courses were still attended by a minority of medical students and young practitioners, and printed works remained one of the most important sources of knowledge about mental disease. Hence, the publication of the first comprehensive psychiatric textbook in 1858, *The Manual of Psychological Medicine* by John Charles Bucknill and Daniel Hack Tuke, was important for providing instruction on insanity to the medical community. The *Manual* quickly became a standard reading on the subject and presented a systematised, coherent and uncontroversial introduction to medical psychology. It also formulated the consensual foundational medical knowledge on mental diseases and their treatment which helped to solidify psychiatry and support asylum doctors' professional identity.

The main characteristic of the period between 1859 and 1875 was the growing importance of science in medicine. It was not enough for a medical practitioner to be a competent clinician anymore; he had to also be a "man of science" capable of conducting and understanding original research. The same was true for medical psychology: asylums came under pressure to become not just curative institutions but places of research, and medical officers were expected to carry out their own scientific investigations and discover new and effective ways of treating mental illness. Medical education had to change accordingly and started prioritising scientific disciplines within the medical curriculum. Alienists saw their branch of medicine as scientific; however, ideas of what constituted the science of mental disease were heterogeneous and often contradictory. As explained in Chapter 3, this created both challenges and possibilities for medico-psychological education. The main challenge was that students did not just need science, they needed "textbook science": noncontroversial, coherent and accessible. The complex and ever-changing reality of medico-psychological approaches at the time did not lend themselves easily to the kind of certainty and generalisation required for teaching beginners. At the same time, it presented the possibility of constructing "textbook scientific medical psychology" through developing courses of instruction and writing actual textbooks.

It was in the 1860s and 1870s that the idea of different levels of psychiatric training first became recognised. On the one hand, regular medical students needed a basic introduction to the subject, which would allow them to recognise mental illness in general practice and possibly entice them to consider a career in the asylum system. On the other hand, there were more advanced students and recently qualified medical practitioners who already knew the

basics of medical psychology and had a more developed interest in the subject. This type of student required a more challenging and hands-on training and, at the same time, could handle the complexity and controversial nature of contemporary medico-psychological knowledge. Recognising the differences between the two types of students, James Crichton-Brown was the first to implement a two-level teaching model at the West Riding Lunatic Asylum. He taught an introductory course of lectures to the students at the Leeds School of Medicine and established three-month unpaid residential clerkships for recently qualified medical men. During that period the clerks took part in the day-to-day work of the asylum and conducted their own research in the laboratories and the wards under the supervision of senior medical officers. These clerkships were a form of proto-postgraduate psychiatric training.

Education on mental diseases continued to develop in those two strands: introductory courses for beginners and advanced training. The first took form through the MPA's campaign for including mental disease in the compulsory medical curriculum, which I traced in Chapter 4. By the mid-1870s the British asylum system had grown into a network of mammoth overcrowded institutions, which employed several hundred medical officers in total. Alienists also began to carve career paths for themselves outside the walls of the asylum. They advanced to the posts of commissioners in lunacy or chancery visitors, became lecturers at medical schools, found success as researchers or writers, occupied positions of power in medical corporations and the GMC, gave expert testimony in courts and established profitable private practices. Hence, medical psychology became a desirable career direction for some practitioners and including an introductory course into the medical curriculum would thus benefit students and widen their job prospects. Moreover, all practicing medical men at some points in their career had to deal with mental patients: they might be called to certify someone's insanity, needed to be able to recognise early signs of mental disease in their regular patients and advise on the necessity of confinement in an asylum, and they might be called to provide medical services to an insane person treated at home. The MPA insisted that all medical students consequently needed a compulsory course on mental diseases. Their campaign gathered significant support amongst the larger medical community and succeeded in 1885, when the GMC officially made mental disease a part of the standard medical curriculum.

Although the success of the MPA's campaign was to a large degree determined by their relentless lobbying, there were some significant historically contingent factors which contributed to this outcome. One of them was the generational change in the GMC which occurred in the early 1880s and brought new younger members who were less opposed to medical specialisation. Another important factor that swayed the GMC's decision was the

sensationalised coverage of court cases featuring the insanity defence. Public disagreements between medical witnesses during trials and what was perceived by the public as their blunders were often ridiculed in the press and threatened the authority of all medical practitioners, not just alienists. This was evident in the newspaper coverage of the Dublin Castle scandal in 1883-1884, which had a powerful effect on the opinion of the GMC members and informed their decision to add medical psychology to the compulsory curriculum.

Chapter 5 followed the development of the other educational strand – the establishment of the postgraduate professional qualification in medical psychology. The MPA introduced its own certificate (CPM) in the same year as their campaign for compulsory education finally succeeded. In the first four years, the future of the CPM looked promising, as it attracted growing numbers of candidates. In fact, in the beginning it was considered such as success that the MPA was inspired to create another certification programme — the Mental Nursing Certificate — which launched in 1891. However, the CPM did not live up to the MPA's expectations: after the initial enthusiasm the number of candidates plummeted and from 1898 until 1914 it did not rise above 10 per year. In contrast to the CPM, the Mental Nursing Certificate became popular, with several hundred candidates taking the examination every year.

The failure of the CPM highlights the importance of considering the developments in psychiatry in relation to the larger context of medical education. One of the main reasons for the lack of interest in the certificate was that its programme almost completely duplicated the compulsory course that all medical students had to take to qualify. Another reason was that the whole scheme did not conform to the main trends in medical education at the time: it was not specialised enough, it was not connected to a university, it did not offer a competitive advantage in the labour market, and it did not allow people who had genuine interest in the subject to engage with it sufficiently deeply. This, again, becomes especially clear when the failure of the CPM is compared to the success of the Mental Nursing Certificate, which followed the larger trend of the professionalisation of nursing and provided new knowledge and concrete advantages in securing profitable employment. For decades before establishing the CPM, the MPA had been working to demonstrate that it was a part of the conservative medical mainstream, that it did not threaten the *status quo* or support radical new ideas such as specialisation. So, when specialisation became accepted and desirable, the MPA was too conservative and cautious to take advantage and offer a truly specialist course that could meet the needs of medical practitioners at the turn of the twentieth century. The programme of postgraduate psychiatric education introduced subsequently — the Diploma in Psychological

Medicine, lauded by Thomas Clouston in 1911 — addressed the most serious problems of the CPM and offered a qualification which suited the new times.

The chapters of this thesis present for the first time a detailed and connected overview of the development of psychiatric education in nineteenth-century Britain. In doing so, the study also offers a number of larger insights that impact the history of psychiatry, the history of medical education, and the history of medical print. Moreover, this is by necessity an exploratory study that offers a large-scale framework, rather than investigating finer details or regional differences, and it consequently opens numerous avenues for further research. The final part of this conclusion examines some of these wider implications of the work.

One of the most important cross-chronological themes that emerges when we piece together this longue durée history of psychiatric education is that, from its inception at the start of the nineteenth century, it was a part of *medical* education. The courses of instruction and publications on the subjects, even when they were available to wider publics, were always aimed at medical students and practitioners as their primary audience. Even though alienists often complained of isolation and practiced far from the usual sites of medical labour they remained a part of the medical profession. Training and certification served as a link to this wider professional identity – all asylum doctors and MPA members were qualified medical practitioners, they all underwent required contemporary training and concomitant socialisation. Hence, when they envisioned psychiatric training, they saw it as a part of medical training (voluntary or compulsory) and not as preparation for a separate profession. We can see the same in the development of education for asylum attendants: as soon as the MPA directed systematic attention to their training they were portrayed as nurses and there were significant efforts to ally them with the newly established professional nursing association. Even though this alliance was not achieved, the training of mental nurses was inherently medical and required them to learn regular hospital nursing and first aid in addition to asylum work. Thus, even though the day-to-day activities and practices of asylum medical staff were different from their colleagues in other branches of the profession, they remained connected socially and culturally. Professional education and training were important instruments to forge this connection.

This significantly revises the common view of psychiatry in nineteenth-century Britain as separate from general medicine and scorned by other medical practitioners.[2] In its place, it

[2] See, for example, Smith 1981a; Turner 1991; Renvoize 1991; Scull 1993; Scull et al. 1996; Oppenheim 1991.

offers a new perspective on psychiatry as an area of medical knowledge and practice that became specialised notably early and was entangled with other social, political and cultural concerns. Much of the resistance of the medical establishment to psychiatry was not to its distinctive nature, but rather can be explained by the vicious resistance of medical elites to specialisation of any kind throughout the century. My account of the history of psychiatric education also challenges the widespread assumption that new medical officers arrived at asylums completely untrained, or that most general medical practitioners were ignorant about mental disease. As we have seen, from the beginning of the nineteenth century medical men were exposed to a wide array of content on insanity in professional periodicals and from the mid-century courses on insanity were frequently offered at medical schools across the country. Finally, from 1885 all medical students had to attend a course on psychiatry in order to qualify. One term of instruction may not seem like a substantial training but, if we consider that at the time the entire period of study for a medical qualification was four years, it becomes apparent that mental disease was allocated a sizable part of the curriculum.

Knowledge of the ways in which alienists were trained aids our understanding of psychiatric practices and research. For example, the prevalence of somatic and physiological explanations of mental illness and the persistent attempts to discover the causes of insanity in lesions of the brain can be partially explained by the fact that these approaches received particular emphasis in what was taught to medical practitioners and reflected the established way to approach the study of any disease. Detailed comparative studies of contemporary research and diagnostic practices in other areas of medicine can better inform our interpretation of alienists' activities. This opens another avenue of research – the history of psychiatry outside the walls of the asylums – which nonetheless remains a part of the medical story.

The findings of this thesis will also be important for understanding the history of psychiatry in Britain in the first half of the twentieth century. British medical psychology at the end of the nineteenth century was widely considered a backwater compared to other Western European countries due to pervasive therapeutic pessimism, the crisis of the asylum system, rigid adherence to organic explanations of mental illness and the resistance of the medical profession to specialisation.[3] However, nineteenth-century British alienists' work to establish systematic training in psychological medicine led to the formation of an infrastructure for

Shorter 1997; Hide 2014; Takabayashi 2017; Degerman 2019.

[3] On late-nineteenth-century British psychiatry, see, for example Takabayashi 2017; Scull 1993; Shorter 1997; Ellis 2020; Clark 1981; Danziger 1982; Hide 2014; Ion and Beer 2002. On specialisation see Weisz 2003, 2006; Casper and Welsh 2016; Hanley 2015.

sharing psychiatric knowledge. When, in the early twentieth-century, new ideas were developed, such as Kraepelinian clinical psychiatry and early psychodynamic approaches, there was an established system of education and communication that allowed those ideas to spread efficiently. The existence of this infrastructure is an important factor to consider when explaining the transformation of British psychiatry into a flourishing discipline leading the world in new methods of analysis, group therapy and medical intervention by mid-twentieth century.

Beyond the history of psychiatry, this account of the development of psychiatric training also importantly contributes to the history of medical education and specialisation in Britain. It demonstrates that there exists a way of incorporating psychiatry into the big picture without ignoring its unique character.[4] The debates surrounding education on mental disease, the justification of its importance and the arguments of the opposition shed light on the contemporary understanding of the role of a medical practitioner, the goals and functions of medical education and the needs of medical students. Although now psychiatry is a compulsory part of medical education and mental health services are integrated into the NHS, there are still discussions about the optimal place of psychiatry within the medical curriculum and the pedagogical challenges in educating medical practitioners about mental health.[5]

This thesis also contributes to our understanding of the history of the nineteenth-century print culture. Throughout the period new forms of publications, such as medical and scientific periodicals and formal educational texts, played an important role in psychiatric education. Not only did they offer important modes of communicating information about mental health to medical students and practitioners, but they also provided a forum for the discussion of pedagogical approaches in medical psychology. This study has also made clear that the success of educational medical publications, as in the cases of Alexander Morison and Thomas Laycock, often involved an interplay between lecturing and publication that is worthy of further study. Although I have only been able to touch upon it, printed imagery is another aspect of psychiatric education that became increasingly important and merits further investigation.

Until now the history of psychiatric education has been overlooked by scholars. It is regrettable and exciting in equal measures. Regrettable, because, as this thesis demonstrated, it

[4] Currently psychiatry is either excluded from such studies or mentioned alongside other specialisms without any analysis of its peculiar status within medicine. See, for example, Weisz 2003, 2006; Bonner 1995; Burnham 1998; Peterson 1978.

[5] For more on the current state of psychiatric education in Britain see Ajaz et al. 2016; Barry et al. 2012; Curtis-Barton and Eagles 2011; Korzun 2011; Kuri 2020; Lyons 2013; Health Education England 2017.

is an important area of research which can revise and enrich current historiography. Exciting, because it is a previously uncharted territory waiting to be explored. This thesis reveals how rich and stimulating the history of psychiatric education can be. However, it is inevitably an exploratory study, and the work done here highlights several especially promising directions for future.

First, there is a need for more tightly focused studies to supplement, correct and confront the general framework offered in this thesis. Research into specific courses, including their organisation, content and audiences would offer a more detailed understanding of psychiatric pedagogy, as would paying closer attention to the use of visual materials, both in publications and in lectures.[6] There is a need for accounts of educational experiences of ordinary students, both those who went on to work in asylums and those who chose different career paths. A prosopography of psychiatric students and psychiatric teachers would provide further understanding of their circumstances, needs, goals and lives and illuminate the ways alienists negotiated the requirements of their role as asylum practitioners and the demands of teaching. Last, but not least, it is important to recover the voices and experiences of patients who became embroiled in psychiatric training: how did they experience their encounters with students in the wards or during the practical parts of student examinations?

Secondly, we need to continue the story started in this thesis by examining the history of British psychiatric education in the twentieth century. The new century brought about profound changes in the map of medical and scientific knowledge, standards of practice and research and larger societal attitudes to health and illness. It would be valuable to investigate the role psychiatric education played in redrawing the boundaries between psychiatry, psychology, general medicine and pseudoscience. Another possible project which comes with time constraints would be to look for and gather oral histories from psychiatrists who were trained in the 1970s and 1980s, when psychiatry finally became a postgraduate medical degree, as the experiences of student life rarely get recorded in detail and many of these memories would be lost with the people who hold them.

Another promising research direction is the development of mental nurses' training. There is a wealth of archival materials on the Mental Nursing Certificate, the training leading to it, examination papers, instructional textbooks, prizes for excellence and so on.[7] Mental

[6] Although several historians, such as Alison Pearn (2010), Mark Jackson (1995) and Katherine Rawling (2011, 2017; 2021b), have published on aspects of using visual materials in teaching psychiatry, there has been no concerted effort to focus on the evolution of visual material in teaching.
[7] This archive is held at the Royal College of Psychiatrists.

nursing is a uniquely British qualification which developed at the same time as general nursing; however, there has been little research into this qualification and the relationship between general and mental nursing.[8] Furthermore, the predecessors of mental nurses, asylum attendants, received training in the institutions where they worked long before a formal qualification was established. These early forms of training have not yet been studied at all. A good entry point into research of the pre-qualification training would be the archive of the Society for Improving the Conditions of the Insane, which gave awards to asylum attendants for excellent service.[9]

Finally, the history of psychiatric education in other countries is also severely under-researched.[10] Creating trans-national and trans-cultural histories of psychiatric training would provide important insights into the spread and reception of ideas about mental illness across state borders. Considering that educational tourism was a common practice among the nineteenth-century medical students and practitioners it would be extremely valuable to trace their training outside their countries of origin and cross-pollination of ideas and practices. Furthermore, it might be beneficial to improve our understanding of how different countries regarded each other at different time periods, in terms of their relative proficiency in psychiatry and the value of their educational systems.

[8] Scholars' interest in the history of mental nursing has been steadily increasing in the recent years, although training has not yet featured prominently in publications on the topic. For more on mental nursing see, for example, Neuendorf 2019; Nolan 1993, 1996; McCrae and Nolan 2016; Borsay and Dale 2015; McCrae 2014; T. Dickinson 2015; York 2012; Monk 2009; Hide 2014: 65–90; Ellis 2001: 235–277.

[9] This archive is held at the Royal College of Physicians of Edinburgh.

[10] For some examples of studies of psychiatric education outside of Britain see Kovács 2020; Wübben 2016; Engstrom 2004: 14–173; Goldstein 1987: 120–151; Boschma 2003: 81–112; Weiss 2012.

Bibliography

Archives

Lothian Health Service Archive, Edinburgh.

Royal College of Physicians, Edinburgh.

Royal College of Psychiatrists, London.

The Retreat Archive, Borthwick Institute for Archives, University of York.

University of Leeds Archive, Special Collections, Leeds University Library.

West Yorkshire Archive Service, Wakefield.

Books and Articles

All newspaper articles, parliamentary papers, websites and anonymous articles from historical periodicals are cited in full in footnotes and are therefore not included here.

Primary Sources

[Anon.]. 1882. *The Great Guiteau Trial: With Life of the Cowardly Assassin* (Philadelphia: Barclay)

Abernethy, John. 1825. *Physiological Lectures Addressed to the College of Surgeons* (London: Longman, Hurst, Rees, Orme and Brown)

Armstrong, John. 1825. 'Lectures on the Principles and Practice of Physic', *Lancet*, 3: 39–47

Arnold, Thomas. 1782. *Observations on the Nature, Kinds, Causes and Prevention of Insanity, Lunacy and Madness*, 2 vols (London: G. Robinson and T. Cadell)

Bainbrigge, W. H. 1845. 'Introductory Lecture to the Course of Clinical Surgery; Delivered in the Theatre, at the Northern Hospital, Liverpool (Concluded)', *Provincial Medical & Surgical Journal*, 9: 717–20

Basham, W. R. 1846. ‘A Course of Lectures on Clinical Medicine. Lecture I’, *Provincial Medical & Surgical Journal*, 10: 509–11

Beck, Theodric Romeyn, and John B. Beck. 1836. *Elements of Medical Jurisprudence* (London: Longman, Rees, Orme, Brown, Green, and Longman)

Browne, W. A. F. 1837. *What Asylums Were, Are, and Ought to Be* (Edinburgh: Adam and Charles Black)

Bucknill, John Charles, and Daniel Hack Tuke. 1858. *A Manual of Psychological Medicine* (London: Churchill)

———. 1874. *A Manual of Psychological Medicine*, 3rd ed. (London: Churchill)

Clark, Campbell. 1884. ‘The Special Training of Asylum Attendants’, *Journal of Mental Science*, 29: 459–66

Clark, James. 1869. *A Memoir of John Conolly, M.D., D.C.L., Comprising a Sketch of the Treatment of the Insane in Europe and America* (London: John Murray)

Clouston, Thomas Smith. 1911. ‘The Diploma in Psychiatry’, *Journal of Mental Science*, 57: 207–18

Conolly, John. 1828. *An Introductory Lecture Delivered in the University of London on Thursday, October 2, 1828* (London: Taylor)

———. 1830. *An Inquiry Concerning the Indications of Insanity: With Suggestions for the Better Protection and Care of the Insane* (London: John Taylor)

———. 1845–46. ‘Clinical Lectures on the Principal Forms of Insanity, Delivered in the Middlesex Lunatic Asylum at Hanwell’, *Lancet*, 46: 357–356, 414–418, 467–470, 525–528, 581–585, 639–643; 47: 1–4, 55–58, 110–116, 171–175, 233–237, 287–289, 349–354, 401–404, 453–456, 513–517, 565–568, 617–620.

———. 1856. *The Treatment of the Insane without Mechanical Restraint* (London: Smith, Elder and Co)

———. 1860. ‘Recollections of the Varieties of Insanity. Part I: The Hanwell Asylum’, *Medical Times and Gazette*, 1: 836–39

———. 1868. *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* (London: Dawsons of Pall Mall)

Combe, Andrew. 1831. *Observations on Mental Derangement Being an Application of the Principles of Phrenology to the Elucidation of the Causes, Symptoms, Nature, and Treatment of Insanity* (Edinburgh and London: John Anderson Jun. and Longman, Rees, Orme, Brown, & Green)

Cormack and Semple. 1851. 'The Hospitals of London', *London Journal of Medicine*, 3: 82–90

Crichton, Alexander. 1798a. *An Inquiry into the Nature and Origins of Mental Derangement, Comprehending a Concise System of Physiology and Pathology of the Human Mind, and History of the Passions and Their Effects*, 2 vols (London: T. Cadell, Junior, and W. Davies)

Crichton-Browne, James. 1861. *The Clinical Teaching of Psychology: A Valedictory Address* (Edinburgh: James Nichol)

———. 1869. 'Correspondence: The Education, Position, and Pay of Assistant Medical Officers of County Asylums', *Journal of Mental Science*, 14: 599–601

———. 1871–1874. 'Clinical Lectures on Mental and Cerebral Diseases', *BMJ*, 1 (1871): 441–442, 467–468; 2 (1871): 113–114, 145–146; 2 (1872): 403–406, 429–431; 1 (1873): 425–427, 455–457; 1 (1874): 601–603, 640–643

———. 1880. 'An Address Delivered at The Opening of The Section of Psychology, at the Annual Meeting of The British Medical Association', *BMJ,* 2: 262–267

Darwin, Charles. 1859. *On the Origin of Species by Means of Natural Selection, or, The Preservation of Favoured Races in the Struggle for Life* (London: John Murray)

———. 1872. *The Expression of the Emotions in Man and Animals* (London: John Murray)

Duncan, Andrew. 1808. 'Observations on the General Treatment of Lunatics, as a Branch of Medical Police', *Edinburgh Medical and Surgical Journal*, 4: 144–51

Duncan, James F. 1875. 'Presidential Address at the Annual Meeting of the Medico-

Psychological Association', *Journal of Mental Science*, 21: 313–38

Eames, J. A. 1885. 'Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association, Held at Queen's College, Cork, August 4, 1885', *Journal of Mental Science*, 31: 315–27

Elliotson, John. 1831. 'St. Thomas Hospital: Clinical Lecture', *Lancet,* 16: 134–45

Farr, Samuel. 1815. *Elements of Medical Jurisprudence, or a Succinct and Compendious Description of Such Tokens in the Human Body as Are Requisite to Determine the Judgement of a Coroner, and Courts of Law* (London: J. Callow)

Forbes, John, Alexander Tweedie, and John Conolly, eds. 1832–35. *The Cyclopaedia of Practical Medicine; Comprising Treatises on the Nature and Treatment of Diseases, Materia Medica and Therapeutics, Medical Jurisprudence, etc.*, 4 vols (London: Sherwood, Gilbert and Piper)

Granville, J. Mortimer. 1877. *The Care and Cure of the Insane: The Reports of the Lancet Commission on Lunatic Asylums, 1875–6–7,* 2 vols (London: Hardwicke and Bogue)

Halliday, Andre. 1828. *A General View of the Present State of Lunatics, and Lunatic Asylums in Great Britain and Ireland and in Some Other Kingdoms* (London: Thomas and George Underwood)

Haslam, John. 1798. *Observations on Insanity with Practical Remarks on the Disease, and an Account of the Morbid Appearances on Dissection* (London: F. and C. Rivington)

Hawkins, Charles. 1865. *The Works of Sir Benjamin Collins Brodie, Vol. 1* (London: Longman, Green, Longman, Roberts, & Green)

Hill, Robert Gardiner. 1839. *Total Abolition of Personal Restraint in the Treatment of the Insane* (London: Simpkin, Marshall and Co)

Johnson, J. 1792. *Guide for Gentlemen Studying Medicine at the University of Edinburgh* (London: J. Robinson)

Laycock, Thomas. 1838a. 'A Selection of Cases Presenting Aggravated and Irregular Forms of Hysteria; and an Analysis of Their Phenomena. No. 1. – Hysteria Ischuria',

Edinburgh Medical and Surgical Journal, 49: 78–109

———. 1838b. ‘A Selection of Cases Presenting Aggravated and Irregular Forms of Hysteria, and an Analysis of Their Phenomena. No. II. Containing, – 1. Hysterical Haemorrhages. 2. Hysterical Nervous Afflictions. 3. Part of the Analysis’, *Edinburgh Medical and Surgical Journal*, 49: 436–61

———. 1838c. ‘Analytical Essay on Irregular and Aggravated Forms of Hysteria’, *Edinburgh Medical and Surgical Journal*, 50: 302–56

———. 1838d. ‘On Anomalous Forms of Hysteria (No. 2 Continued). Containing Analysis of New Phenomena’, *Edinburgh Medical and Surgical Journal*, 50: 24–66

———. 1840. *A Treatise on the Nervous Diseases of Women; Comprising an Inquiry into the Nature, Causes, and Treatment of Spinal and Hysterical Disorders* (London: Longman, Orme, Brown, Green, and Longmans)

———. 1860. *Mind and Brain: Or the Correlation of Consciousness and Organisation,* 2 vols (Edinburgh: Sutherland and Knox)

———. 1861. ‘The Scientific Place and Principles of Medical Psychology: An Introductory Address’, *Edinburgh Medical Journal*, 6: 1053–64

———. 1862a. *On the Principles and Method of a Practical Science of Mind: A Reply to a Criticism* (London: Adlard)

———. 1862b. *The Antagonism of Law and Medicine in Insanity, and Its Consequences: An Introductory Lecture* (Edinburgh: Oliver & Boyd)

———. 1863. ‘The Edinburgh Teaching of Psychology’, *Journal of Mental Science*, 9: 444–45

———. 1869. ‘The Objects and Organization of the Medico-Psychological Association; The Anniversary Address’, *Journal of Mental Science*, 15: 327–43

———. 1871a. ‘The Teaching of Psychological Medicine and Mental Pathology at Edinburgh’, *BMJ*, 1: 293

———. 1871b. ‘The Teaching of Psychological Medicine and Mental Pathology at

Edinburgh', *BMJ*, 1: 382

———. 1874a. 'The Teaching and Practice of Psychological Medicine as Influenced by Classifications of Insanity', *Lancet*, 103: 4–6

———. 1874b. 'The Teaching and Practice of Psychological Medicine as Influenced by Classifications of Insanity', *Lancet*, 103: 48–50

———. 1995. '"To Ask the Suffrages of the Patrons": Thomas Laycock and the Edinburgh Chair of Medicine, 1855', ed. by Michael Barfoot, *Medical History*, Supplement 15

Lush, John Alfred. 1879. 'Presidential Address Delivered at the Annual Meeting of the Medico-Psychological Association', *Journal of Mental Science,* 25: 310–314

Male, George Edward. 1818. *Elements of Juridical or Forensic Medicine for the Use of Medical Men, Coroners, and Barristers* (London: E. Cox and son, and H. Butterworth)

Maudsley, Henry. 1866. 'Memoir of the Late John Conolly, M.D.', *Journal of Mental Science*, 12: 151–74

———. 1867. *Physiology and Pathology of the Mind* (London: Macmillan)

———. 1870. *Body and Mind: An Enquiry into Their Connection and Mutual Influence Specially in Reference to Mental Disorders* (London: Macmillan)

Moore, Edward B. 1885. 'On the Necessity of All Medical Students Attending a Course of Lectures and Receiving Clinical Instruction Also in Psychological Medicine', *Journal of Mental Science*, 31: 38–46

Morison, Alexander. 1825. *Outlines of Lectures on Mental Diseases* (Edinburgh: Maclachlan & Stewart)

———. 1826. *Outlines of Lectures on Mental Diseases*, 2nd ed. (London: Longman, Rees, Orme, Brown & Green)

———. 1829. *Outlines of Lectures on Mental Diseases*, 3rd ed. (Edinburgh: Maclachlan & Stewart)

———. 1838. *The Physiognomy of Mental Diseases* (London: Longman & Co)

———. 1840. *The Physiognomy of Mental Diseases* (London: Longman & Co)

———. 1843. *The Physiognomy of Mental Diseases*, 2nd ed. (London: Longman & Co)

———. 1848. *Outlines of Lectures on the Nature, Causes, and Treatment of Insanity*, 4th ed. (London: Longman, Brown, Green, and Longmans)

Orchard, J. C. 1881. 'On Medical Education', *Lancet*, 118: 50–51, 87–88

Orr, David. 1912. 'Some Points Complementary to the Instruction of Post-Graduate Instruction in Psychiatry', *Journal of Mental Science*, 58: 39–47

Paget, James, and Stephen Paget. 1902. *Memoirs and Letters of Sir James Paget* (London: Longmans, Green, and Co)

Paris, J. A., and J. S. M. Fonblanque. 1823. *Medical Jurisprudence,* 3 vols. (London: W. Phillips)

Perfect, William. 1785. *Cases of Insanity, the Epilepsy, Hypochondriacal Affection, Hysteric Passion, and Nervous Disorders, Successfully Treated* (Rochester: printed by T. Fisher at Rochester; and sold by J. Dodsley; N. Conant; and J. Bew, London)

———. 1787. *Select Cases in the Different Species of Insanity, Lunacy and Madness with the Modes of Practice as Adopted in the Treatment of Each* (Rochester: W. Gilman)

Pierce, Bedford. 1912. 'Some Remarks on the Diploma in Psychological Medicine', *Journal of Mental Science,* 58: 185–88

Pinel, Philippe. 1800. *Traité médico-philosophique sur l'aliénation mentale ou la manie* (Paris: Caille et Ravier)

———. 1806. *A Treatise on Insanity, in Which Are Contained the Principles of a New and More Practical Nosology of Maniacal Disorders*, trans. by David Davis (Sheffield: W. Todd)

Porter, John K. 1882. *Guiteau Trial: Closing Speech to the Jury* (New York: John Polhemus)

Prichard, James Cowles. 1835. *A Treatise on Insanity and Other Disorders Affecting the Mind* (London: Sherwood, Gilbert, and Piper)

Rows, R. G. 1912. ‘The Development of Psychiatric Science as a Branch of Public Health’, *Journal of Mental Science*, 58: 25–39

Rush, Benjamin. 1812. *Medical Inquiries and Observations upon the Diseases of the Mind* (Philadelphia: Kimber & Richardson)

Ryan, Michael. 1831. *A Manual of Medical Jurisprudence* (London: Renshaw and Rush)

Sankey, W. H. O. 1866. *Lectures on Mental Diseases* (London: Churchill)

Sigmond, George G. 1837. ‘Lectures on Materia Medica and Therapeutics, Now in Course of Delivery at the Windmill-Street School of Medicine’, *Lancet,* 28: 567–72

Skae, David. 1863. ‘A Rational and Practical Classification of Insanity’, *Journal of Mental Science*, 9: 309–19

Spurzheim, J. G. 1817. *Observations on the Deranged Manifestations of the Mind or Insanity* (London: Baldwin, Cradock and Joy)

T., J. B. 1871a. ‘The Teaching of Psychological Medicine and Mental Pathology at Edinburgh’, *BMJ*, 1: 325

———. 1871b. ‘The Teaching of Psychological Medicine and Mental Pathology at Edinburgh’, *BMJ*, 1: 434–435

Thompson, A. T. 1836. ‘Lectures of Medical Jurisprudence, Now in Course of Delivery at the University of London’, *Lancet*, 27: 145–52

———. 1837. ‘Lectures of Medical Jurisprudence, Now in Course of Delivery at the University of London’, *Lancet*, 27: 801–06

Thomson, D. G. 1908. ‘The Teaching of Psychiatry’, *Journal of Mental Science*, 54: 550–59

———. 1910. ‘On the Teaching of Psychiatry’, *British Medical Journal*, 2: 1247–49

Tuke, Daniel Hack. 1856. ‘On the Various Forms of Mental Disorder, (Being the Substance of Lectures Delivered at the York School of Medicine)’, *Asylum Journal of Mental Science*, 2: 445–66

———. 1857. ‘On the Various Forms of Mental Disorder, (Being the Substance of Lectures Delivered at the York School of Medicine)’, *Asylum Journal of Mental Science*, 3: 81–113; 218–46; 335–64; 443–64

Tuke, Samuel. 1813. *Description of the Retreat: An Institution Near York, for Insane Persons of the Society of Friends* (York: W. Alexander)

———. 1815. *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums* (York: W. Alexander)

Webster, John. 1842. *Observations on the Admission of Medical Pupils to the Wards of Bethlem Hospital, for the Purpose of Studying Mental Diseases* (London: T. Brettell)

West Riding Pauper Lunatic Asylum. 1873. *Regulations & Orders of the Committee of Visitors for the Management and Conduct of the Asylum. Female Department* (Wakefield: B. W. Allen)

Whitcombe, Edmund Banks. 1891. ‘Presidential Address Delivered at the Fiftieth Annual Meeting of the Medico-Psychological Association Held at Birmingham, July 23, 1891’, *Journal of Mental Science*, 37: 501–14

White, Ernest W. 1884. ‘Lunacy Law Reform’, *Lancet*, 124: 1138–39

Secondary Sources

Adriaens, Pieter R., and Andreas De Block. 2010. ‘The Evolutionary Turn in Psychiatry: A Historical Overview’, *History of Psychiatry*, 21: 131–43

Aidan, Collins. 2013. ‘Eleonora Fleury Captured’, *British Journal of Psychiatry*, 203: 5

Ajaz, Ali et al. 2016. ‘BASH: Badmouthing, Attitudes and Stigmatisation in Healthcare as Experienced by Medical Students’, *BJPsych Bulletin*, 40: 97–102

Alexander, Franz, and S. Selesnick. 1966. *The History of Psychiatry: An Evaluation of Psychiatric Thought and Practice from Prehistoric Times to the Present* (New York: Harper and Row)

Almond, Sophie. 2020. ‘The Forgotten Life of Annie Reay Barker, M.D’, *Social History of Medicine*, 34: 828–50

———. 2021. ‘The Medical Women’s Federation (MWF): 1879–1948’ (unpublished doctoral thesis, University of Leicester)

Allderidge, P. H. 1974. ‘Criminal Insanity: Bethlem to Broadmoor’, *Proceedings of the Royal Society of Medicine*, 67: 897–904

———. 1991. ‘The Foundation of the Maudsley Hospital’, in *150 Years of Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 79–88

Anderson, R. D. 1992. *Universities and Elites in Britain since 1800*, Studies in Economic and Social History (London: Macmillan)

Andrews, Jonathan. 1997. ‘A Failure to Flourish? David Yellowlees and the Glasgow School of Psychiatry’, *History of Psychiatry*, 8: 177–212, 333–60

———. 1998. ‘Case Notes, Case Histories, and the Patient’s Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century’, *Social History of Medicine*, 11: 255–81

———. 2010. ‘From Stack-Firing to Pyromania: Medico-Legal Concepts of Insane Arson in British, US and European Contexts, c. 1800–1913’, *History of Psychiatry*, 21: 243–60, 387–405

———. 2011. ‘Death and the Dead-House in Victorian Asylums: Necroscopy versus Mourning at the Royal Edinburgh Asylum, c. 1832–1901’, *History of Psychiatry*, 23: 6–26

Andrews, Jonathan, Asa Briggs, Roy Porter, Penny Tucker, and Keir Waddington. 1997. *The History of Bethlem* (London and New York: Routledge)

Andrews, Jonathan, and Anne Digby, eds. 2004. *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam and New York: Rodopi)

Andrews, Jonathan, and Andrew Scull. 2001. *Undertaker of the Mind: John Monro and Mad-*

Doctoring in Eighteenth-Century England (Berkeley: University of California Press)

Argles, Michael. 1964. *South Kensington to Robbins: An Account of English Technical and Scientific Education since 1851* (London: Longmans)

Avery, Caroline Louise. 2020. 'Importing the Stethoscope: The Uptake of Mediate Auscultation by British Practitioners, 1816–1850' (unpublished doctoral thesis, University of Leeds)

Backus, Margot Gayle. 2008. '"Odd Jobs": James Joyce, Oscar Wilde, and the Scandal Fragment', *Joyce Studies Annual*, 2008: 105–45

———. 2013. *Scandal Work: James Joyce, the New Journalism, and the Home Rule Newspaper Wars* (Notre Dame, Indiana: University of Notre Dame Press)

Barfoot, Michael. 2009. 'David Skae: Resident Asylum Physician; Scientific General Practitioner of Insanity', *Medical History*, 53: 469–88

Barry, Natalie et al. 2012. 'Medical Students and a Career in Psychiatry: A Discussion', *Psychiatrist*, 36 (2012): 79–80

Bartlett, Peter. 1999. 'The Asylum and the Poor Law: The Productive Alliance', in *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective*, ed. by Joseph Melling and Bill Forsythe (London and New York: Routledge), pp. 48–67

———. 2001. 'Legal Insanity in the Nineteenth Century', *Social History of Medicine*, 14: 107–31

Bartlett, Peter, and David Wright, eds. 1999. *Outside the Walls of the Asylum: The History of Care in the Community 1750–2000* (London & New Brunswick, NJ: Athlone Press)

Bartrip, Peter. 1992. 'The British Medical Journal: A Retrospect', in *Medical Journals and Medical Knowledge: Historical Essays*, ed. by W. F. Bynum, Stephen Lock, and Roy Porter (London and New York: Routledge), pp. 126–45

Bates, A. W. 2008. '"Indecent and Demoralising Representations": Public Anatomy Museums in Mid-Victorian England', *Medical History*, 52: 1–22

Berkenkotter, Carol. 2008. *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry* (Columbia, S.C.: University of South Carolina Press)

Berkowitz, Carin. 2012. 'Systems of Display: The Making of Anatomical Knowledge in Enlightenment Britain', *British Journal for the History of Science*, 46: 359–87

Berrios, German E. 1996. *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century* (Cambridge: Cambridge University Press)

Berrios, German E., and Hugh Freeman, eds. 1991. *150 Years of British Psychiatry, 1841–1991* (London: Gaskell)

Berrios, German E., and Roy Porter. 1995. *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone)

Beveridge, Allan. 1991. 'Thomas Clouston and the Edinburgh School of Psychiatry', in *150 Years of Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 359–388

———. 1998a. 'Life in the Asylum: Patients' Letters from Morningside, 1873–1908', *History of Psychiatry*, 9: 431–69

———. 1998b. 'The Odd Couple: The Partnership of J. C. Bucknill and D. H. Tuke', *Psychiatric Bulletin*, 22: 52–56

———. 2018. 'Sir Alexander Morison and The Physiognomy of Mental Diseases', *Journal of the Royal College of Physicians of Edinburgh*, 48: 272–83, 352–67

Beveridge, Allan, and Morag Williams. 2002. 'Inside "The Lunatic Manufacturing Company": The Persecuted World of John Gilmour', *History of Psychiatry*, 13: 19–49

Bewley, Thomas. 2008. *Madness to Mental Illness: A History of the Royal College of Psychiatrists* (London: The Royal College of Psychiatrists)

Blake, Catriona. 1990. *The Charge of the Parasols: Women's Entry to the Medical Profession* (London: The Women's Press)

Bonner, Thomas Neville. 1992. *To the Ends of the Earth: Women's Search for Education in Medicine* (London and Cambridge, MA: Harvard University Press)

———. 1995. *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750–1945* (New York and Oxford: Oxford University Press)

Borsay, Anne, and Pamela Dale, eds. 2015. *Mental Health Nursing: The Working Lives of Paid Carers in the Nineteenth and Twentieth Centuries* (Manchester: Manchester University Press)

Boschma, Geertje. 2003. *The Rise of Mental Health Nursing*: *A History of Psychiatric Care in Dutch Asylums, 1890-1920* (Amsterdam: Amsterdam University Press)

Bowler, Peter J., and Iwan R. Morus. 2005. *Making Modern Science: A Historical Survey* (Chicago: University of Chicago Press)

Brake, Laurel. 1988. 'The Old Journalism and the New: Forms of Cultural Production in London in the 1880s', in *Papers for the Millions: The New Journalism in Britain, 1850s to 1914*, ed. by Joel H. Weiner (New York: Greenwood Press), pp. 1–24

Bressey, Caroline. 2011. 'The City of Others: Photographs from the City of London Asylum Archive', *Interdisciplinary Studies in the Long 19th Century*, 19 <https://doi.org/10.16995/ntn.625>

Brock, W. H. 1990. 'Science Education', in *Companion to the History of Modern Science*, ed. by R. C. Olby, G. N. Cantor, J. R. R. Christie, and M. J. S. Hodge (London and New York: Routledge), pp. 946–59

Brown, Michael. 2006. 'Rethinking Early Nineteenth-Century Asylum Reform', *Historical Journal*, 49: 425–52

———. 2009. 'Medicine, Reform and the "End" of Charity in Early Nineteenth-Century England', *English Historical Review*, 124: 1353–88

———. 2011. *Performing Medicine: Medical Culture and Identity in Provincial England, c. 1760–1850* (Manchester and New York: Manchester University Press)

———. 2014. '"Bats, Rats and Barristers": The *Lancet*, Libel and the Radical Stylistics of Early Nineteenth-Century English Medicine', *Social History*, 39: 182–209

Browne, Janet. 1985. ‘Darwin and the Face of Madness’, in *The Anatomy of Madness: Essays on the History of Psychiatry*, ed. by W. F. Bynum, Roy Porter, and Michael Shepherd (London and New York: Routledge), pp. 151–65

———. 1986. ‘Darwin and the Expression of the Emotions’, in *The Darwinian Heritage*, ed. by David Kohn and Malcolm J. Kottler (Princeton: Princeton University Press), pp. 307–26

Brückner, Burkhart. 2021. ‘Lunatics’ Rights Activism in Britain and the German Empire, 1870–1920: A European Perspective’, in *Patient Voices in Britain, 1840–1948*, ed. by Anne Hanley and Jessica Meyer (Manchester: Manchester University Press), pp. 91–124

Brunton, Warwick. 2015. ‘“At Variance with the Most Elementary Principles”: The State of British Colonial Lunatic Asylums in 1863’, *History of Psychiatry*, 26: 147–65

Bucchi, Massimiano. 2008. ‘Of Deficits, Deviations and Dialogues: Theories of Public Communication of Science’, in *Handbook of Public Communication of Science and Technology*, ed. by B. Trench and M. Bucchi (London and New York: Routledge), pp. 57–76

Buklijas, Tatjana. 2017. ‘The Laboratory and the Asylum: Francis Walker Mott and the Pathological Laboratory’, *History of Psychiatry*, 28: 311–25

Burney, Ian A. 2003. ‘Medicine in the Age of Reform’, in *Rethinking the Age of Reform: Britain 1780–1850*, ed. by Arthur Burns and Joanna Innes (Cambridge: Cambridge University Press), pp. 163–81

———. 2007. ‘The Politics of Particularism: Medicalization and Medical Reform in Nineteenth-Century Britain’, in *Medicine, Madness and Social History: Essays in Honour of Roy Porter*, ed. by Roberta Bivins and John V. Pickstone (Basingstoke: Palgrave Macmillan), pp. 46–57

Burnham, John C. 1998. *How the Idea of Profession Changed the Writing of Medical History* (London: Wellcome Institute for the History of Medicine, 1998)

Butler, Stella V. F. 1981. ‘Science and the Education of Doctors in the Nineteenth Century: A

Study of British Medical Schools with Particular Reference to the Development and Uses of Physiology' (unpublished doctoral thesis, University of Manchester)

———. 1986. 'A Transformation in Training: The Formation of University Medical Faculties in Manchester, Leeds, and Liverpool, 1870–84', *Medical History*, 30: 115–32

———. 1988.'Centers and Peripheries: The Development of British Physiology, 1870–1914', *Journal of the History of Biology*, 21: 473–500

Bynum, William F. 1991. 'Tuke's Dictionary and Psychiatry at the Turn of the Century', in *150 Years of Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 163–79

———. 1994. *Science and the Practice of Medicine in the Nineteenth Century* (New York: Cambridge University Press)

———. 2008. *The History of Medicine: A Very Short Introduction* (Oxford: Oxford University Press)

Bynum, William F., Stephen Lock, and Roy Porter, eds. 1992. *Medical Journals and Medical Knowledge: Historical Essays* (London and New York: Routledge)

Bynum, William F., and Janice C. Wilson. 1992. 'Periodical Knowledge: Medical Journals and Their Editors in Nineteenth-Century Britain', in *Medical Journals and Medical Knowledge: Historical Essays*, ed. by W. F. Bynum, Stephen Lock, and Roy Porter (London and New York: Routledge), pp. 29–47

Bynum, William F., and Roy Porter, eds. 1987. *Medical Fringe and Medical Orthodoxy 1750–1850* (London: Croom Helm)

Carson, John. 2018. '"Every Expression Is Watched": Mind, Medical Expertise and Display in the Nineteenth-Century English Courtroom', *Social Studies of Science*, 48: 891–918

Casper, Stephen T. 2014. *The Neurologist: A History of a Medical Speciality in Modern Britain, c. 1789–2000* (Manchester and New York: Manchester University Press)

Casper, Stephen T., and Rick Welsh. 2016. 'British Romantic Generalism in the Age of Specialism, 1870–1990', *Social History of Medicine*, 29: 154–74

Champion, Axelle. 2021. ‘Child and Adolescent Psychiatry in France and Scotland, 1870–1914’ (unpublished doctoral thesis, University of Edinburgh)

Chaney, Sarah. 2013. ‘Self-Mutilation and Psychiatry: Impulse, Identity and the Unconscious in British Explanations of Self-Inflicted Injury, c. 1864 –1914’ (unpublished doctoral thesis, University College London)

———. 2015. ‘“No ‘Sane’ Person Would Have Any Idea”: Patients’ Involvement in Late Nineteenth-Century British Asylum Psychiatry’, *Medical History*, 60: 37–53

Cherry, Steven, and Roger Munting. 2005. ‘“Exercise Is the Thing”? Sport and the Asylum c.1850–1950’, *International Journal of the History of Sport*, 22: 42–58

Clark, Michael J. 1981. ‘The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry’, in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. by Andrew Scull (Philadelphia: University of Pennsylvania Press), pp. 271–312

Cloître, Michael, and Terry Shinn. 1985. 'Expository Practice: Social, Cognitive and Epistemological Linkage', in *Expository Science: Forms and Functions of Popularisation*, ed. by T. Shinn and R. Whitley (Dordrecht and Boston: D. Reidel), pp. 31–60

Cocks, H. G. 2003. *Nameless Offences: Homosexual Desire in the 19th Century* (London and New York: I. B. Tauris)

Cohen, Ed. 1993. *Talk on the Wilde Side: Towards a Genealogy of a Discourse on Male Sexualities* (New York and London: Routledge)

Cohen, Susan. 2019. *Nurses and Nursing* (Stroud: Amberley)

Coleborne, Catharine. 2007. *Reading ‘Madness’: Gender and Difference in the Colonial Asylum in Victoria, Australia, 1848–1888* (Perth: API Network)

Cooter, Roger. 1981. ‘Phrenology and British Alienists, ca. 1825–1845’, in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. by Andrew Scull (Philadelphia: University of Pennsylvania Press), pp. 58–104

———. 1984. *The Cultural Meaning of Popular Science: Phrenology and the Organization of Consent in Nineteenth-Century Britain* (Cambridge: Cambridge University Press)

———. 1989. *Phrenology in the British Isles: An Annotated, Historical Bibliography and Index* (Metuchen, N. J. & London: The Scarecrow Press)

Cooter, Roger, ed. 1988. *Studies in the History of Alternative Medicine* (Basingstoke: Macmillan in association with St Antony's College Oxford)

Cope, Zachary. 1956. 'Influence of the Society of Apothecaries upon Medical Education', *British Medical Journal*, 1: 1–6

Cowen, David L. 1969. 'Liberty, Laissez-Faire and Licensure in Nineteenth-Century Britain', *Bulletin of the History of Medicine*, 43: 30–40

Cox, Catherine. 2012. *Negotiating Insanity in the Southeast of Ireland, 1820–1900* (Manchester: Manchester University Press)

Cox, Catherine, and Hilary Marland. 2018a. 'Broken Minds and Beaten Bodies: Cultures of Harm and the Management of Mental Illness in Mid- to Late Nineteenth-Century English and Irish Prisons', *Social History of Medicine*, 31: 688–710

———. 2018b. '"He Must Die or Go Mad in This Place": Prisoners, Insanity and the Pentonville Model Prison Experiment, 1842–1852', *Bulletin of the History of Medicine*, 92: 78–109

Cox, Howard, and Simon Mowatt. 2020. 'The Economics of Press and Periodical Production', in *The Edinburgh History of the British and Irish Press. Volume 2, Expansion and Evolution, 1800–1900*, ed. by David Finkelstein (Edinburgh: Edinburgh University Press)

Cox, Stephanie C., Clare Hocking, and Deborah Payne. 2018. 'Showers: From a Violent Treatment to an Agent of Cleansing', *History of Psychiatry*, 30: 58–76

Crammer, John L. 1994. 'English Asylums and English Doctors: Where Scull is Wrong'. *History of Psychiatry*, 5: 103–115

———. 1996. 'Training and Education in British Psychiatry 1770–1970', in *150 Years of*

British Psychiatry Volume II: The Aftermath, ed. by Hugh Freeman and German E. Berrios (London & Atlantic Highlands, NJ: Athlone), pp. 209–42

Cross, Simon. 2010. *Mediating Madness: Mental Distress and Cultural Representation* (Basingstoke: Palgrave Macmillan)

Cullen, Lynsey T. 2017. 'Post-Mortem in the Victorian Asylum: Practice, Purpose and Findings at the Littlemore County Lunatic Asylum, 1886–7', *History of Psychiatry*, 28: 280–96

Curtis-Barton, Marie T., and John M. Eagles. 2011. 'Factors That Discourage Medical Students from Pursuing a career in Psychiatry', *Psychiatrist*, 35: 425–429

Danston, Lorraine, and Peter Galison. 2010. *Objectivity* (New York: Zone Books)

Daskalova, Mila. 2021. 'Printing as Poison, Printing as Cure: Work and Health in the Nineteenth-Century Printing Office and Asylum', *Book History*, 24: 58–84

Danziger, Kurt. 1982. 'Mid-Nineteenth-Century British Psycho-Physiology: A Neglected Chapter in the History of Psychology', in *The Problematic Science: Psychology in Nineteenth-Century Thought*, ed. by William R. Woodward and Mitchell G. Ash (New York: Praeger), pp. 119–46

Dawson, Gowan. 2004. 'The Review of Reviews and the New Journalism in Late-Victorian Britain', in *Science in the Nineteenth-Century Periodical: Reading the Magazine of Nature*, ed. by Geoffrey Cantor, Gowan Dawson, Graeme Gooday, Richard Noakes, Sally Shuttleworth, and Jonathan R. Topham (Cambridge: Cambridge University Press), pp. 172–98

Dawson, Gowan, Bernard Lightman, Sally Shuttleworth, and Jonathan R. Topham, eds. 2020. *Science Periodicals in Nineteenth-Century Britain: Constructing Scientific Communities* (Chicago: University of Chicago Press)

Dawson, Gowan, and Jonathan R. Topham. 2020a. 'Introduction: Constructing Scientific Communities', in *Science Periodicals in Nineteenth-Century Britain: Constructing Scientific Communities*, ed. by Gowan Dawson, Bernard Lightman, Sally Shuttleworth, and Jonathan R. Topham (Chicago and London: University of Chicago Press), pp. 1–

33

———. 2020b. ‘Scientific, Medical, and Technical Periodicals in Nineteenth-Century Britain: New Formats for New Readers’, in *Science Periodicals in Nineteenth-Century Britain: Constructing Scientific Communities*, ed. by Gowan Dawson, Bernard Lightman, Sally Shuttleworth, and Jonathan R. Topham (Chicago: University of Chicago Press), p. 35–64

Deacon, Harriet. 2003. ‘Insanity, Institutions and Society: The Case of Robben Island Lunatic Asylum, 1846–1910’, in *The Confinement of the Insane: International Perspectives, 1800–1965*, ed. by Roy Porter and David Wright (Cambridge: Cambridge University Press), pp. 20–53

Degerman, Dan. 2019. ‘“Am I Mad?”: The Windham Case and Victorian Resistance to Psychiatry’, *History of Psychiatry*, 30: 457–68

Desmond, Adrian. 1989. *The Politics of Evolution: Morphology, Medicine, and Reform in Radical London* (Chicago and London: University of Chicago Press)

———. 2001. ‘Redefining the X Axis: “Professionals”, “Amateurs”, and the Making of Mid-Victorian Biology—A Progress Report’, *Journal of the History of Biology*, 34: 3–50

Digby, Anne. 1983. ‘Changes in the Asylum: The Case of York, 1777–1815’, *Economic History Review*, 36: 218–39

———. 1985. *Madness, Morality and Medicine: A Study of the York Retreat, 1796–1914* (London: Cambridge University Press)

———. 1994. *Making a Medical Living: Doctors and Patients in the English Market Medicine, 1720–1911* (Cambridge: Cambridge University Press)

Dickinson, Tommy. 2015. *“Curing Queers” Mental Nurses and Their Patients, 1935–74* (Manchester: Manchester University Press)

Dobbing, Cara. 2016. ‘An Undiscovered Victorian Institution of Care: A Short Introduction to the Cumberland and Westmorland Joint Lunatic Asylum’, *Family & Community History*, 19: 3–16

Earls, Averill. 2019. ‘Unnatural Offenses of English Import: The Political Association of Englishness and Same-Sex Desire in Nineteenth-Century Irish Nationalist Media’, *Journal of the History of Sexuality*, 28: 396–424

Eastoe, Stef. 2020. *Idiocy, Imbecility and Insanity in Victorian Society: Caterham Asylum, 1867–1911* (Palgrave Macmillan)

Eddy, Matthew Daniel. 2016. ‘The Interactive Notebook: How Students Learned to Keep Notes during the Scottish Enlightenment’, *Book History*, 19: 86–131

Edgington, Barry. 2007. ‘A Space for Moral Management: The York Retreat’s Influence on Asylum Design’, in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, ed. by Leslie Topp, James E. Moran, and Jonathan Andrews (New York and London: Routledge), pp. 85–104

Eigen, Joel Peter. 1995. *Witnessing Insanity: Madness and Mad-Doctors in the English Court* (New Haven: Yale University Press)

———. 1999. ‘Lesion of the Will: Medical Resolve and Criminal Responsibility in Victorian Insanity Trials’, *Law and Society Review*, 33: 425–59

———. 2010. ‘Diagnosing Homicidal Mania: Forensic Psychiatry and the Purposeless Murder’, *Medical History*, 54: 433–56

———. 2016. *Mad-Doctors in the Dock: Defending the Diagnosis, 1760–1913* (Baltimore: Johns Hopkins University Press)

Ellis, Robert, Sarah Kendal, and Steven J. Taylor, eds. 2021. *Voices in the History of Madness: Personal and Professional Perspectives on Mental Health and Illness* (Cham: Palgrave Macmillan)

Ellis, Robert. 2001. ‘A Field of Practise or a Mere House of Detention?’: The Asylum and Its Integration, with Special Reference to the County Asylums of Yorkshire, c.1844–1888’ (unpublished doctoral thesis, University of Huddersfield)

———. 2006. ‘The Asylum, the Poor Law, and a Reassessment of the Four–Shilling Grant: Admissions to the County Asylums of Yorkshire in the Nineteenth Century’, *Social History of Medicine*, 19: 55–71

———. 2008. ‘The Asylum, the Poor Law and the Growth of County Asylums in Nineteenth-Century Yorkshire’, *Northern History*, 45 (2008), 279–93

———. 2013. ‘Asylums and Sport: Participation, Isolation and the Role of Cricket in the Treatment of the Insane’, *International Journal of the History of Sport*, 30: 83–101

———. 2020. *London and Its Asylums, 1888–1914: Politics and Madness* (Basingstoke: Palgrave Macmillan)

Engel, A. J. 1983. *From Clergyman to Don: The Rise of the Academic Profession in Nineteenth-Century Oxford* (Oxford: Clarendon Press)

Engstrom, Eric J. 2004. *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca: Cornell University Press)

Evans, Bonnie, Shahina Rahman, and Edgar Jones. 2008. ‘Managing the `unmanageable’: Interwar Child Psychiatry at the Maudsley Hospital, London’, *History of Psychiatry*, 19: 454–75

Farquharson, Lauren. 2016. ‘A “Scottish Poor Law of Lunacy”? Poor Law, Lunacy Law and Scotland’s Parochial Asylums’, *History of Psychiatry*, 28: 15–28

Feather, John. 1988. *A History of British Publishing* (London: Croom Helm)

Fennelly, Katherine. 2014. ‘Out of Sound, out of Mind: Noise Control in Early Nineteenth-Century Lunatic Asylums in England and Ireland’, *Word Archaeology*, 46: 416–30

———. 2019. *An Archaeology of Lunacy: Managing Madness in Early Nineteenth-Century Asylums* (Manchester: Manchester University Press)

Finn, Michael Anthony. 2012. ‘The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century’ (unpublished doctoral thesis, University of Leeds)

Fish, Frank. 1965. ‘David Skae, M.D., F.R.C.S., Founder of the Edinburgh School of Psychiatry’, *Medical History*, 9: 36–53

Fleck, Ludwik. 1979. *Genesis and Development of a Scientific Fact* (Chicago and London: University of Chicago Press)

Forsythe, Bill, Joseph Melling, and Richard Adair. 1999. 'Politics of Lunacy: Central State Regulation and the Devon Pauper Lunatic Asylum, 1845–1914', in *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective*, ed. by Joseph Melling and Bill Forsythe (London and New York: Routledge), pp. 68–92

Foucault, Michel. 1995. *Madness and Civilization: A History of Insanity in the Age of Reason* (London: Routledge)

Frampton, Sally. 2020a. '"A Borderland in Ethics": Medical Journals, the Public and the Medical Profession in Nineteenth-Century Britain', in *Science Periodicals in Nineteenth-Century Britain: Constructing Scientific Communities*, ed. by Gowan Dawson, Bernard Lightman, Sally Shuttleworth, and Jonathan R. Topham (Chicago: University of Chicago Press), pp. 311–36

———. 2020b. 'The Medical Press and Its Public', in *The Edinburgh History of the British and Irish Press. Volume 2, Expansion and Evolution, 1800–1900*, ed. by David Finkelstein (Edinburgh: Edinburgh University Press), pp. 438–56

Frank Jr., Justin A. 1967. 'Non-Restraint and Robert Gardiner Hill', *Bulletin of the History of Medicine*, 41: 140–60

Franklin, Bridget. 2002. 'Hospital – Heritage – Home: Reconstructing the Nineteenth Century Lunatic Asylum', *Housing, Theory and Society*, 19: 170–84

Freeman, Hugh. 2010. 'Psychiatry in Britain, c. 1900', *History of Psychiatry*, 21: 312–24

Freeman, Hugh, and German E. Berrios, eds. 1996. *150 Years of British Psychiatry Volume II: The Aftermath* (London & Atlantic Highlands, NJ: Athlone)

Fyfe, Aileen. 2002. 'Publishing and the Classics: Paley's *Natural Theology* and the Nineteenth-Century Scientific Canon', *Studies in History and Philosophy of Science*, 33: 729–51

———. 2012. *Steam-Powered Knowledge: William Chambers and the Business of Publishing, 1820–1860* (Chicago and London: University of Chicago Press)

Gilman, Sandler L. 1988. *Disease and Representation Images of Illness from Madness to Aids* (Ithaca: Cornell University Press)

Goad, Anne Elizabeth. 2020. ‘Managing the Mad: Lunacy Provision and Social Control in Kent, 1774–1874’ (unpublished doctoral thesis, Queen Mary University of London)

Godbey, Emily. 2000. ‘Picture Me Sane: Photography and the Magic Lantern in a Nineteenth-Century Asylum’, *American Studies*, 41: 31–69

Goffman, Erving. 2017. *Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates* (London and New York: Routledge)

Golding, Rosemary. 2020. ‘“Appeasing the Unstrung Mental Faculties”: Listening to Music in Nineteenth-Century Lunatic Asylums’, *Nineteenth-Century Music Review*, 17: 403–25

———. 2021. *Music and Moral Management in the Nineteenth-Century English Lunatic Asylum* (Palgrave Macmillan)

Goldstein, Jan Ellen. 1987. *Console and Classify: The French Psychiatric Profession In the Nineteenth Century* (Cambridge: Cambridge University Press)

Gooday, Graeme. 1990. ‘Precision Measurement and the Genesis of Physics Teaching Laboratories in Victorian Britain’, *BJHS*, 23: 21–51

———. 1991a. ‘“Nature” in the Laboratory: Domestication and Discipline with the Microscope in Victorian Life Science’, *BJHS*, 24: 307–41

———. 1991b. ‘Teaching Telegraphy and Electronics in the Physics Laboratory: William Ayrton and the Creation of an Academic Space for Electrical Engineering in Britain 1873–1884’, *History of Technology*, 13: 73–111

———. 2005. ‘Fear, Shunning, and Valuelessness: Controversy over the Use of “Cambridge” Mathematics in Late Victorian Electro-Technology’, in *Pedagogy and the Practice of Science: Historical and Contemporary Perspectives*, ed. by David Kaiser (Cambridge, Mass. and London: MIT Press), pp. 111–50

———. 2008. ‘Liars, Experts and Authorities’, *History of Science*, 46: 431–56

Grob, Gerald N. 1998. ‘Psychiatry’s Holy Grail: The Search for the Mechanisms of Mental Diseases’, *Bulletin of the History of Medicine*, 72: 189–219

Graham, Aaron. 2021. ‘The Global Politics of Medical Reform in Britain and Jamaica in the

Early Nineteenth Century', *Social History of Medicine*, 34: 766–87

Green-Lewis, Jennifer. 1996. *Framing the Victorians: Photography and the Culture of Realism* (Ithaca: Cornell University Press)

Hanley, Anne. 2015. 'Venereology at the Polyclinic: Postgraduate Medical Education Among General Practitioners in England, 1899–1914', *Medical History*, 59: 199–221

Hardy, Anne. 2001. *Health and Medicine in Britain since 1860* (New York: Palgrave)

Harling, Philip. 2003. 'Parliament, the State, and "Old Corruption": Conceptualizing Reform, c. 1790–1832', in *Rethinking the Age of Reform: Britain 1780–1850*, ed. by Arthur Burns and Joanna Innes (Cambridge: Cambridge University Press), pp. 98–113

Hasson, Ezra. 2010. 'Capacity to Marry: Law, Medicine and Conceptions of Insanity', *Social History of Medicine*, 23: 1–20

Haynes, Douglas M. 2017. *Fit to Practice: Empire, Race, Gender, and the Making of British Medicine, 1850–1980* (Rochester, NY: University of Rochester Press)

Health Education England. 2017. *Stepping Forward to 2020/21: The Mental Health Workforce Plan for England* < https://bit.ly/2y7eHrZ > [accessed 12 August 2022]

Heyningen, Elizabeth van. 1996. 'Jane Elizabeth Waterston – Southern Africa's First Woman Doctor', *Journal of Medical Biography*, 4: 208–13

Hickman, Clare. 2009. 'Cheerful Prospects and Tranquil Restoration: The Visual Experience of Landscape as Part of the Therapeutic Regime of the British Asylum, 1800–60', *History of Psychiatry*, 20: 425–41

Hide, Louise. 2014. *Gender and Class in English Asylums, 1890–1914* (Basingstoke, Hampshire: Palgrave Macmillan)

Holland, Sarah. 2021. 'Narrating and Navigating Patient Experiences of Farm Work in English Psychiatric Institutions, 1845–1914', in *Patient Voices in Britain, 1840–1948*, ed. by Anne Hanley and Jessica Meyer (Manchester: Manchester University Press), pp. 125–53

Holloway, S. W. F. 1964. 'Medical Education in England, 1830–1858: A Sociological

Analysis', *History*, 49: 299–324

———. 1966. 'The Apothecaries' Act of 1815: A Reinterpretation. Part I.', *Medical History*, 10: 107–29, 221–36

Hunter, Richard. 1973. 'Psychiatry and Neurology: Psychosyndrome or Brain Disease', *Proceedings of the Royal Society of Medicine*, 66: 359–64

Hunter, Richard A., and H. Phillip Greenberg. 1956. 'Sir William Gull and Psychiatry', *Guy's Hospital Reports*, 105: 361–275

Hunter, Richard, and Ida Macalpine, eds. 1963. *Three Hundred Years of Psychiatry 1535–1860: A History Presented in Selected English Texts* (London: Oxford University Press)

———. 1968. 'Introduction', in *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, by John Conolly (London: Dawsons of Pall Mall), pp. 7–38

Hutchison, Iain. 2011. 'Institutionalization of Mentally-Impaired Children in Scotland, c.1855–1914', *History of Psychiatry*, 22: 416–33

Ion, R. M., and M. D. Beer. 2002a. 'The British Reaction to Dementia Praecox 1893–1913', *History of Psychiatry*, 13: 285–304, 419–31

Jacyna, L.S. 1982. 'Somatic Theories of Mind and the Interests of Medicine in Britain, 1850–1879', *Medical History*, 26: 233–58

———. 1995. 'Theory of Medicine, Science of Life: The Place of Physiology Teaching in the Edinburgh Medical Curriculum, 1790–1870', in *The History of Medical Education in Britain*, ed. by Vivian Nutton and Roy Porter (Amsterdam and Atlanta, GA: Rodopi), pp. 141–52

———. 2000. *Lost Words: Narratives of Language and the Brain, 1825–1926* (Princeton and Oxford: Princeton University Press)

Jacyna, L. S., and Edwin Clarke. 1987. *Nineteenth-Century Origins of Neuroscientific Concepts* (London: University of California Press)

Jackson, Mark. 1995. '"Images of Deviance:" Visual Representations of Mental Defectives in Early Twentieth-Century Medical Texts', *British Journal for the History of Science*,

28: 319–37

———. 2000. *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Late Victorian and Edwardian England* (Manchester and New York: Manchester University Press)

Jain, Sanjeev. 2003. 'Psychiatry and Confinement in India', in *The Confinement of the Insane: International Perspectives, 1800–1965*, ed. by Roy Porter and David Wright (Cambridge: Cambridge University Press), pp. 273–98

Janssen, Diederik F. 2021. 'Melancholia Scytharum: The Early Modern Psychiatry of Transgender Identification', *History of Psychiatry*, 32: 270–88

Jansson, Åsa. 2013. 'From Statistics to Diagnostics: Medical Certificates, Melancholia, and "Suicidal Propensities" in Victorian Psychiatry', *Journal of Social History*, 46: 716–31

———. 2022. *From Melancholia to Depression: Disordered Mood in Nineteenth-Century Psychiatry* (Palgrave Macmillan)

James, Frederick Ernest. 1991. 'The Development of Psychiatric Education in the United Kingdom', *Psychiatric Bulletin*, 15: 631–34

———. 1996. 'The Life and Work of Thomas Laycock, 1812–1876' (unpublished doctoral thesis, University College London, 1996)

Jarrett, Simon. 2020. *Those They Called Idiots: The Idea of the Disabled Mind from 1700 to the Present Day* (London: Reaktion Books)

Jones, Carol A. G. 1994. *Expert Witnesses: Science, Medicine and the Practice of Law* (Oxford: Clarendon Press)

Jones, Kathleen. 1955. *Lunacy, Law and Conscience, 1744–1845: The Social History of the Care of the Insane* (London: Routledge & Kegan Paul)

———. 1991a. 'The Culture of Mental Hospital', in 150 *Years of British Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 17–28

———. 1991b. 'Law and Mental Health: Sticks or Carrots?', in *150 Years of British Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London:

Gaskell), pp. 89–102

Jones, Kevin Matthew. 2019. ‘The “Table of the Forms of Insanity”: The History of the Psychiatric Nosology of the Medico-Psychological Association of the United Kingdom and the British Isles’ (unpublished doctoral thesis, University of Leeds)

Jordanova, Ludmilla. 1990. ‘Medicine and Visual Culture’, *Social History of Medicine*, 3: 89–99

———. 1993. ‘The Art and Science of Seeing in Medicine: Physiognomy 1780–1820’, in *Medicine and the Five Senses*, ed. by W. F. Bynum and Roy Porter (Cambridge: Cambridge University Press), pp. 122–33

Kaiser, David (ed). 2005. *Pedagogy and the Practice of Science: Historical and Contemporary Perspectives* (Cambridge, Mass. and London: MIT Press)

Kearin, Madeline Bourque. 2020. ‘Strange Cases: Jekyll & Hyde Narratives as Rhetorical Strategy in Sir Alexander Morison’s Physiognomy of Mental Diseases’, *Journal of the History of Medicine and Allied Sciences*, 75: 151–70

———. 2022. ‘Dirty Bread, Forced Feeding, and Tea Parties: The Uses and Abuses of Food in Nineteenth-Century Insane Asylums’, *Journal of Medical Humanities*, 43: 95–116

Kelly, Brendan D. 2011. ‘Custody, Care and Criminality: Clinical Aspects of Forensic Psychiatric Institutionalisation in Late Nineteenth- and Early Twentieth-Century Ireland’ (unpublished doctoral thesis, University of Northampton)

Kelly, Laura. 2012. *Irish Women in Medicine, c.1880–1920s: Origins, Education and Careers* (Manchester: Manchester University Press)

———. 2017. *Irish Medical Education and Student Culture, c.1850–1950* (Liverpool: Liverpool University Press)

Kemp, Martin. 1993. ‘“The Mark of Truth”: Looking and Learning in Some Anatomical Illustrations from the Renaissance and the Eighteenth Century’, in *Medicine and the Five Senses*, ed. by W. F. Bynum and Roy Porter (Cambridge: Cambridge University Press), pp. 85–121

Knowles, Thomas, and Serena Trowbridge, eds. 2015. *Insanity and the Lunatic Asylum in the Nineteenth Century* (London and New York: Routledge)

Korzun, Ania et al. 2011. 'Teaching Medical Students and Recruitment to Psychiatry: Attitudes of Psychiatric Clinicians, Academics and Trainees', *Psychiatrist*, 35: 350–353

Kovács, Janka. 2020. 'Az orvostudomány „legsetétebb mezeje" – pszichológiai ismeretek a Habsburg birodalom orvosi fakultásainak tananyagában a 18–19. század fordulóján', *Gerundum*, 9: 78–103

Kraft, Alison, and Samuel J. M. M. Alberti. 2003. '"Equal Though Different": Laboratories, Museums, and the Institutional Development of Biology in Late-Victorian Northern England', *Studies in History and Philosophy of Biological and Biomedical Sciences*, 34: 203–36

Kryssova, Evgeniya. 2020. '"Tales of Wonder and Horror": Subject of Insanity in the Leeds Newspaper Press Miscellanies During the Late Georgian Era', *Northern History*, 57: 215–28

Kuri, Ashvin. 2020. 'The Shortage of Psychiatrists — A Student's View', *InSPIre the Mind*, <https://medium.com/inspire-the-mind/the-shortage-of-psychiatrists-a-students-view-2fb66a24912e> [accessed 12 August 2022]

Kusukawa, Sachiko. 2012. *Picturing the Book of Nature: Image, Text, and Argument in Sixteenth-Century Human Anatomy and Medical Botany* (Chicago: University of Chicago Press, 2012)

Laing, R. D. 1990. *The Divided Self: An Existential Study in Sanity and Madness* (Harmondsworth: Penguin)

Laragy, Georgina. 2013. ''A Peculiar Species of Felony": Suicide, Medicine, and the Law in Victorian Britain and Ireland', *Journal of Social History*, 46: 732–43

Lawrence, Christopher. 1985. 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850–1914', *Journal of Contemporary History*, 20: 503–20

Lawrence, Susan C. 1988. 'Entrepreneurs and Private Enterprise: The Development of Medical Lecturing in London, 1775–1820', *Bulletin of the History of Medicine*, 62: 171–92

———. 1996. *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth-Century London* (Cambridge: Cambridge University Press)

Leigh, Denis. 1961. *The Historical Development of British Psychiatry: Volume I, 18th and 19th Century* (London: Pergamon Press)

Levine-Clark, Marjorie. 2000. 'Dysfunctional Domesticity: Female Insanity and Family Relationships among the West Riding Poor in the Mid-Nineteenth Century', *Journal of Family History*, 25: 341–61

———. 2004. '"Embarrassed Circumstances": Gender, Poverty, and Insanity in the West Riding of England in the Early-Victorian Years', in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, ed. by Jonathan Andrews and Anne Digby (Amsterdam and New York: Rodopi), pp. 123–48

Lewis, Aubrey. 1967. 'Psychiatric Education: Background and History', in *The State of Psychiatry: Essays and Addresses* (London: Routledge and Kegan Paul), pp. 113–24

Lightman, Bernard, ed. 1997. *Victorian Science in Context* (Chicago and London: University of Chicago Press)

Lindsay, Murray. 1893. 'Presidential Address Delivered at the Fifty–Second Annual Meeting of the Medico-Psychological Association', *Journal of Mental Science,* 39: 473–491

Loudon, Irvine. 1986. *Medical Care and the General Practitioner, 1750–1850* (Oxford: Clarendon Press)

———. 1995. 'Medical Education and Medical Reform', in *The History of Medical Education in Britain*, ed. by Vivian Nutton and Roy Porter (Amsterdam and Atlanta, GA: Rodopi), pp. 229–49

Loudon, Jean, and Irvine Loudon. 1992. 'Medicine, Politics and the Medical Periodical 1800–50', in *Medical Journals and Medical Knowledge: Historical Essays*, ed. by W. F. Bynum, Stephen Lock, and Roy Porter (London and New York: Routledge), pp. 49–68

Loughran, Tracey. 2008. 'Hysteria and Neurasthenia in Pre–1914 British Medical Discourse and in Histories of Shell–Shock', *History of Psychiatry*, 19: 25–46

Lundgren, Anders and Bensaude–Vincent, Bernadette, eds. 2000. *Communicating Chemistry: Textbooks and Their Audiences, 1789–1939* (Canton, MA: Watson Publishing International)

Lyons, Zaza. 2013. 'Attitudes of Medical Students Toward Psychiatry and Psychiatry as a Career: A Systematic Review', *Academic Psychiatry*, 37: 150–157

MacDonald, Michael. 1981. *Mystical Bedlam: Madness, Anxiety and Healing in Seventeenth Century England* (Cambridge: Cambridge University Press)

MacKenzie, Charlotte. 1992. *Psychiatry for the Rich: A History of Ticehurst Private Asylum 1792–1917* (London and New York: Routledge)

Mackintosh, Alan. 2021. 'Warfare and the Launch of Medical Reform in Britain, 1793–1811', *Medical History*, 65: 267–85

Marland, Hilary. 2003. 'Disappointment and Desolation: Women, Doctors and Interpretations of Puerperal Insanity in the Nineteenth Century', *History of Psychiatry*, 14: 303–320

———. 2004. *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave Macmillan)

Mauger, Alice. 2017. *The Cost of Insanity in Nineteenth-Century Ireland: Public, Voluntary and Private Asylum Care* (Basingstoke: Palgrave Macmillan)

McCandless, Peter. 1981. 'Liberty and Lunacy: The Victorians and Wrongful Confinement', in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. by Andrew Scull (Philadelphia: University of Pennsylvania Press), pp. 339–62

McCarthy, Angela. 2012. 'Connections and Divergences: Lunatic Asylums in New Zealand and the Homelands before 1910', *Health and History*, 14: 12–37

McCarthy, Angela, Cathrine Coleborne, Maree O'Connor, and Elspeth Knewstubb. 2017. 'Lives in the Asylum Record, 1864 to 1910: Utilising Large Data Collection for Histories of Psychiatry and Mental Health', *Medical History*, 61: 358–79

McCrae, Niall. 2014. 'Resilience of Institutional Culture: Mental Nursing in a Decade of

Radical Change', *History of Psychiatry*, 25: 70–86

McCrae, Niall, and Peter Nolan. 2016. *The Story of Nursing in British Mental Hospitals: Echoes from the Corridors* (London: Routledge)

McCrae, Niall and M. Wright. 2016. 'Work, Rest and Play: Professional and Social Progress of Nurses at a British Mental Hospital in the Early 20th Century', *Journal of Psychiatric and Mental Health Nursing,* 23: 614–623

Melling, Joseph, Richard Adair, and Bill Forsythe. 1997. '"A Proper Lunatic for Two Years": Pauper Lunatic Children in Victorian and Edwardian England. Child Admissions to the Devon County Asylum, 1845–1914', *Journal of Social History*, 31: 371–405

Melling, Joseph, and Bill Forsythe, eds. 1999. *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective* (London: Routledge)

———. 2006. *The Politics of Madness: The State, Insanity and Society in England, 1845–1914* (London and New York: Routledge)

Melling, Joseph, and Pamela Dale, eds. 2006. *Mental Illness and Learning Disability Since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London and New York: Routledge)

Merkulova, Polina. 2016. 'The Making of a *Manual*: A History of the Classic Textbook of Victorian Psychiatry' (unpublished master's dissertation, University of Leeds)

Merrington, W. R. 1976. *University College Hospital and Its Medical School: A History* (London: Heinemann)

Millard, Candice. 2011. *Destiny of the Republic: A Tale of Madness, Medicine, and the Murder of a President* (New York and London: Doubleday)

Millard, Chris. 2015. *A History of Self-Harm in Britain: A Genealogy of Cutting and Overdosing* (Houndmills: Pelgrave Macmillan)

Miller, Edgar. 2007. 'Variations in the Official Prevalence and Disposal of the Insane in England under the Poor Law, 1850–1900', *History of Psychiatry*, 2007: 25–38

Mills, James H. 2000. *Madness, Cannabis and Colonialism: The 'Native–Only' Lunatic*

Asylums of British India, 1857–1900 (Basingstoke: Macmillan)

Mitchell, Jonathan Paul. 2018. 'Religious Melancholia and the York Retreat 1730–1830' (unpublished doctoral thesis, University of Leeds)

Monk, Lee–Ann. 2008. *Attending Madness: At Work in the Australian Colonial Asylum* (Amsterdam and New York: Rodopi)

———. 2009. 'Working in the Asylum: Attendants to the Insane', *Health and History*, 11: 83–101

Moran, James E. 2018. A Tale of Two Bureaucracies: Asylums and Lunacy Law Paperwork', *Rethinking History*, 22: 419–36

———. 2019. *Madness on Trial: A Transatlantic History of English Civil Law and Lunacy* (Manchester: Manchester University Press)

Murphy, Elaine.2003. 'The Administration of Insanity in England 1800 to 1870', in *The Confinement of the Insane: International Perspectives, 1800–1965*, ed. by Roy Porter and David Wright (Cambridge: Cambridge University Press), pp. 334–49

———. 2006. 'Workhouse Care of the Insane, 1845–90', in *Mental Illness and Learning Disability Since 1850: Finding a Place for Mental Disorder in the United Kingdom*, ed. by Joseph Melling and Pamela Dale (London and New York: Routledge), pp. 24–45

Neuendorf, Mark. 2019. 'Psychiatry's "Others"? Rethinking the Professional Self-Fashioning of British Mental Nurses c. 1900–20', *Medical History*, 63: 291–313

Newman, Charles. 1957. *The Evolution of Medical Education in the Nineteenth Century* (London: Oxford University Press)

Nolan, Peter. 1993. *A History of Mental Health Nursing* (London: Chapman & Hall)

———. 1996. 'Mental Health Nursing in Great Britain', in *150 Years of British Psychiatry Volume II: The Aftermath*, ed. by Hugh Freeman and German E. Berrios (London & Atlantic Highlands, NJ: Athlone), pp. 171–92

Oppenheim, Janet. 1991. *'Shattered Nerves': Doctors, Patients and Depression in Victorian England* (Oxford: Oxford University Press)

O'Shea, Brian, and Jane Falvey. 1996. 'A History of the Richmond Asylum (St. Brendan's Hospital), Dublin', in *150 Years of British Psychiatry Volume II: The Aftermath*, ed. by Hugh Freeman and German E. Berrios (London & Atlantic Highlands, NJ: Athlone), pp. 407–33

Outterson Wood, T. 1896. 'The Early History of the Medico-Psychological Association', *Journal of Mental Science*, 42: 241–60

Owen, Alex. 1989. *The Darkened Room: Women, Power, and Spiritualism in Late Nineteenth Century England* (London: Virago Press)

Palfreyman, Harriet, and Christelle Rabier. 2017. 'Visualizing Surgery: Surgeons' Use of Images, 1600–Present', in *The Palgrave Handbook of the History of Surgery*, ed. by Thomas Schlich (Basingstoke: Palgrave Macmillan), pp. 283–300

Parry–Jones, William Llywelyn. 1972. *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London: Routledge and Kegan Paul)

Pearn, Alison M. 2010. '"This Excellent Observer ...": The Correspondence between Charles Darwin and James Crichton-Browne, 1869–75', *History of Psychiatry*, 21: 160–75

Perkin, Joan. 2002. *The Merry Duchess* (London: Athena Press)

Peschier, Diana. 2019. *Lost Souls: Women, Religion and Mental Illness in the Victorian Asylum* (London: Bloomsbury)

Peterson, M. Jeanne. 1978. *The Medical Profession in Mid-Victorian London* (London: University of California Press)

Philo, Chris. 2004. *A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lewiston, NY: The Edwin Mellen Press)

Philo, Chris, and Jonathan Andrews. 2017. 'Introduction: Histories of Asylums, Insanity and Psychiatry in Scotland', *History of Psychiatry*, 28: 2–14

Pichel, Beatriz. 2016. 'From Facial Expressions to Bodily Gestures: Passions, Photography and

Movement in French 19th-Century Sciences', *History of Human Sciences*, 29: 27–48

Piddock, Susan. 2007. *A Space of Their Own: The Archaeology of Nineteenth Century Lunatic Asylums in Britain, South Australia, and Tasmania* (New York: Springer)

Pines, Malcolm. 1991. 'The Development of the Psychodynamic Movement', in *150 Years of British Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 206–31

Plessis, Rory. 2015. 'Beyond a Clinical Narrative: Casebook Photographs from the Grahamstown Lunatic Asylum, c. 1890s', *Critical Arts*, 29: 88–103

———. 2021. '"Tells His Story Quite Rationally and Collectedly": Examining the Casebooks of the Grahamstown Lunatic Asylum, 1890–1910, for Cases of Delusion Where Patients Voiced Their Life Stories', in *Voices in the History of Madness: Personal and Professional Perspectives on Mental Health and Illness*, ed. by Robert Ellis, Sarah Kendal, and Steven J. Taylor (Cham: Palgrave Macmillan), pp. 137–53

Porter, Martin. 2005. *Windows of the Soul: The Art of Physiognomy in European Culture 1470–1780* (Oxford: Clarendon Press)

Porter, Roy. 1987. *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (Cambridge, Mass.: Harvard University Press)

———. 1992. 'The Rise of Medical Journalism in Britain to 1800', in *Medical Journals and Medical Knowledge: Historical Essays*, ed. by W. F. Bynum, Stephen Lock, and Roy Porter (London and New York: Routledge), pp. 6–21

Porter, Roy, and David Wright, eds. 2003. *The Confinement of the Insane: International Perspectives, 1800–1965* (Cambridge: Cambridge University Press)

Prodger, Phillip. 2009. *Darwin's Camera: Art and Photography in the Theory of Evolution* (Oxford: Oxford University Press)

Quick, Tom. 2014. 'From Phrenology to the Laboratory: Physiological Psychology and the Institution of Science in Britain (c. 1830–80)', *History of the Human Sciences*, 27: 54–73

Raeburn, Toby, Kayla Sale, Paul Saunders, and Aunty Kerrie Doyle. 2022. 'Aboriginal Australian Mental Health During the First 100 Years of Colonization, 1788–1888: A Historical Review of Nineteenth-Century Documents', *History of Psychiatry*, 33: 3–20

Rajpal, Shilpi. 2015. 'Quotidian Madness: Time, Management and Asylums in Colonial North India, c. 1850–1947', *Studies in History*, 31: 206–34

Rawling, Katherine D. B. 2011. 'Visualising Mental Illness: Gender, Medicine and Visual Media, c.1850–1910' (unpublished doctoral thesis, Royal Holloway, University of London)

———. 2017. '"She Sits All Day in the Attitude Depicted in the Photo": Photography and the Psychiatric Patient in the Late Nineteenth Century', *Medical Humanities*, 43: 99–110

———. 2021a. 'Patient Photographs, Patient Voices: Recovering Patient Experience in the Nineteenth-Century Asylum', in *Voices in the History of Madness: Personal and Professional Perspectives on Mental Health and Illness*, ed. by Robert Ellis, Sarah Kendal, and Steven J. Taylor (Cham: Palgrave Macmillan), pp. 237–62

———. 2021b. '"The Annexed Photos Were Taken Today": Photographing Patients in the Late-Nineteenth-Century Asylum', *Social History of Medicine*, 34: 256–84

Reinarz, Jonathan. 2005. 'The Age of Museum Medicine: The Rise and Fall of the Medical Museum of Birmingham's School of Medicine', *Social History of Medicine*, 18: 419–46

Renvoize, Edward. 1991. 'The Association of Medical Officers of Asylums and Hospitals for the Insane, the Medico-Psychological Association, Their Presidents', in *150 Years of British Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 29–78

Richardson, Ruth. 1988. *Death, Dissection and the Destitute* (London: Penguin Books)

———. 2008. *The Making of Mr. Gray's Anatomy: Bodies, Books, Fortune, Fame* (Oxford: Oxford University Press)

Roberts, Michael J. D. 2009. 'The Politics of Professionalization: MPs, Medical Men, and the 1858 Medical Act', *Medical History*, 53: 37–56

Rollin, Henry R. 1991. ‘Whatever Happened to Henry Maudsley?’, in *150 Years of British Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 351–58

———. 1996. ‘Forensic Psychiatry in England: A Retrospective’, in *150 Years of British Psychiatry Volume II: The Aftermath*, ed. by Hugh Freeman and German E. Berrios (London: Athlone Press), pp. 243–67

Rosenthal, Amy Rebok. 2012. ‘Insanity, Family and Community in Late-Victorian Britain’, in *Disabled Children: Contested Caring, 1850–1979* (London: Pickering & Chatto), pp. 29–42

Rosner, Lisa. 1991. *Medical Education in the Age of Improvement: Edinburgh Students and Apprentices, 1760–1826* (Edinburgh: Edinburgh University Press)

Russell, Colin. 1983. *Science and Social Change in Britain and Europe, 1700–1900* (London: Macmillan)

Rothman, David. 1971. *The Discovery of the Asylum* (Boston: Little, Browne)

Saks, Mike, ed. 1992. *Alternative Medicine in Britain* (Oxford: Clarendon Press)

Schwieso, Joshua John. 1996. ‘“Religious Fanaticism” and Wrongful Confinement in Victorian England: The Affair of Louisa Nottidge’, *Social History of Medicine*, 9: 159–74

Scull, Andrew, ed. 1981. *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (London: Athlone Press)

Scull, Andrew. 1979. *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England* (London: Allen Lane)

———. 1993. *The Most Solitary of Afflictions: Madness and Society in Britain, 1700–1900* (New Haven and London: Yale University Press)

———. 1999. ‘Rethinking the History of Asylumdom’, in *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective*, ed. by Joseph Melling and Bill Forsythe (London: Routledge), pp. 295–315

———. 2011a. ‘The Peculiarities of the Scots? Scottish Influences on the Development of English Psychiatry, 1700–1980’, *History of Psychiatry*, 22: 403–15

———. 2011b. *Hysteria: The Disturbing History* (Oxford: Oxford University Press)

Scull, Andrew, Charlotte MacKenzie, and Nicholas Hervey. 1996. *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton, NJ: Princeton University Press)

Sedlmayr, Gerold. 2011. *The Discourse of Madness in Britain, 1790–1815: Medicine, Politics, Literature* (Trier: Wissenschaft-licher Verlag Trier)

Secord, James. 2000. *Victorian Sensation: The Extraordinary Publication, Reception, and Secret Authorship of Vestiges of the Natural History of Creation* (Chicago: University of Chicago Press)

———. 2004. ‘Knowledge in Transit’, *Isis*, 95: 654–72

Sellers, Laura Mary. 2017. ‘Managing Convicts, Understanding Criminals: Medicine and the Development of English Convict Prisons, c. 1837–1886’ (unpublished doctoral thesis, University of Leeds)

Shepherd, Anne, and David Wright. 2002. ‘Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint’, *Medical History*, 46: 175–96

Shepherd, Jade. 2013. ‘“One of the Best Fathers until He Went Out of His Mind”: Paternal Child-Murder, 1864–1900’, *Journal of Victorian Culture*, 18: 17–35

———. 2016a. ‘“I Am Not Very Well I Feel Nearly Mad When I Think of You”: Male Jealousy, Murder and Broadmoor in Late-Victorian Britain’, *Social History of Medicine*, 30: 277–98

———. 2016b. ‘“I Am Very Glad and Cheered When I Hear the Flute”: The Treatment of Criminal Lunatics in Late Victorian Broadmoor’, *Medical History*, 60: 473–91

Shepherd, Michael. 1992. ‘Psychiatric Journals and the Evolution of Psychological Medicine’, in *Medical Journals and Medical Knowledge: Historical Essays*, ed. by William F. Bynum, Stephen Lock, and Roy Porter (London and New York: Routledge), pp. 188–

Shorter, Edward. 1997. *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, Inc.)

Shortt, S. E. D. 1986. *Victorian Lunacy: Richard M. Burke and the Practice of Late Nineteenth-Century Psychiatry* (Cambridge: Cambridge University Press)

Showalter, Elaine. 1987. *The Female Malady: Women, Madness and English Culture, 1830–1980* (London: Virago Press)

Sidlauskas, Susan. 2013. 'Inventing the Medical Portrait: Photography at the "Benevolent Asylum" of Holloway, c. 1885–1889', *Medical Humanities*, 39: 29–37

Simon, Josep. 2011. *Communicating Physics: The Production, Circulation and Appropriation of Ganot's Textbooks in France and England, 1851–1887* (London: Pickering & Chatto)

Singer, Charles, and S. W. F. Holloway. 1960. 'Early Medical Education in England in Relation to the Pre-History of London University', *Medical History*, 4: 1–17

Smith, Cathy. 2006. 'Family, Community and the Victorian Asylum: A Case Study of the Northampton General Lunatic Asylum and Its Pauper Lunatics', *Family & Community History*, 2006: 109–24

———. 2007. 'Parsimony, Power, and Prescriptive Legislation: The Politics of Pauper Lunacy in Northamptonshire, 1845–1876', *Bulletin of the History of Medicine*, 81: 359–85

———. 2011. '"Visitation by God": Rationalizing Death in the Victorian Asylum', *History of Psychiatry*, 23: 104–16

Smith, Leonard D. 1999a. *'Cure, Comfort and Safe Custody': Public Lunatic Asylums in Early Nineteenth-Century England* (London and New York: Leicester University Press)

———. 1999b. 'The County Asylum in the Mixed Economy of Care, 1808–1845', in *Insanity, Institutions, and Society, 1800–1914: A Social History of Madness in Comparative Perspective*, ed. by Joseph Melling and Bill Forsythe (London: Routledge), pp. 33–47

———. 2008. '"Your Very Thankful Inmate": Discovering the Patients of an Early County

Lunatic Asylum', *Social History of Medicine*, 21: 237–52

———. 2012. 'Welcome Release: Perspectives on Death in the Early County Lunatic Asylums, 1810–50', *History of Psychiatry*, 23: 117–28

———. 2014. *Insanity, Race and Colonialism Managing Mental Disorder in the Post-Emancipation British Caribbean, 1838–1914* (Basingstoke: Palgrave Macmillan)

———. 2017. 'Lunatic Asylum in the Workhouse: St Peter's Hospital, Bristol, 1698–1861', *Medical History*, 61: 225–45

———. 2020. *Private Madhouses in England, 1640–1815: Commercialised Care for the Insane* (London: Palgrave)

Smith, Roger. 1981a. *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press)

———. 1981b. 'The Boundary Between Insanity and Criminal Responsibility', in *Mad-Houses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. by Andrew Scull (Philadelphia: University of Philadelphia Press), pp. 363–84

———. 1988. 'The Victorian Controversy about the Insanity Defence', *Journal of the Royal Society of Medicine*, 81: 70–73

———. 1989. 'Forensic Pathology, Scientific Expertise, and the Criminal Law', in *Expert Evidence: Interpreting Science in the Law*, ed. by Roger Smith and Brian Wynne (London and New York: Routledge), pp. 56–92

———. 1991. 'Legal Frameworks for Psychiatry', in *150 Years of British Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 137–51

———. 2013. *Between Mind and Nature: A History of Psychology* (London: Reaktion Books, 2013)

Sposini, Filippo Maria. 2021. 'The Rise of Psychological Physicians: The Certification of Insanity and the Teaching of Medical Psychology', *International Journal of Law and Psychiatry*, 74 <https://doi.org/10.1016/j.ijlp.2020.101667>

Summers, Martin. 2010. '"Suitable Care of the African When Afflicted with Insanity": Race,

Madness, and Social Order in Comparative Perspective', *Bulletin of the History of Medicine*, 84: 58–91

Suzuki, Akihito. 1995. 'The Politics and Ideology of Non-Restraint: The Case of the Hanwell Asylum', *Medical History*, 39: 1–17

———. 2006. *Madness at Home: The Psychiatrist, the Patient, and the Family in England*, 1820–1860 (Berkeley: University of California Press)

———. 2007. 'Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London', in *Medicine, Madness and Social History*, ed. by Roberta Bivins and John V. Pickstone (London: Palgrave Macmillan)

Szasz, Thomas. 1960. 'The Myth of Mental Illness', *American Psychologist*, 15: 113–18

Takabayashi, Akinobu. 2017. 'Surviving the Lunacy Act of 1890: English Psychiatrists and Professional Development during the Early Twentieth Century', *Medical History*, 61: 246–69

Taylor, Steven J. 2014. 'Insanity, Philanthropy and Emigration: Dealing with Insane Children in Late-Nineteenth-Century North-West England', *History of Psychiatry*, 25: 224–36

———. 2016. 'Depraved, Deprived, Dangerous and Deviant: Depicting the Insane Child in England's County Asylums, 1845–1907', *History*, 101: 513–35

Todd, John, and Lawrence Ashworth. 1991. 'The West Riding Asylum and James Crichton-Browne, 1818–76', in *150 Years of British Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (Gaskell, London), pp. 389–418

Tomkins, Alannah. 2012. 'Mad Doctors? The Significance of Medical Practitioners Admitted as Patients to the First English County Asylums up to 1890', *History of Psychiatry*, 23: 437–53

———. 2017. *Medical Misadventure in an Age of Professionalisation, 1780–1890* (Manchester: Manchester University Press)

Topham, Jonathan R. 2000a. 'A Textbook Revolution', in *Books and the Sciences in History*, ed. by M. Frasca-Spada and N. Jardine (Cambridge: Cambridge University Press), pp.

317–37

———. 2000b. ‘Scientific Publishing and the Reading of Science in Nineteenth-Century Britain: A Historiographical Survey and Guide to Sources’, *Studies in History and Philosophy of Science*, 31, 559–612

———. 2000c. ‘BJHS Special Section: Book History and the Sciences: Introduction’, *British Journal for the History of Science*, 33, 155–58

———.2009. ‘Scientific and Medical Textbooks, 1780–1830’, in *The Cambridge History of the Book in Britain*, ed. by Michael F. Suarez and Michael L. Turner (Cambridge: Cambridge University Press), pp. 827–33

———. 2013. ‘Science, Mathematics, and Medicine’, in *The History of Oxford University Press, vol. 2, 1780–1896* (Oxford: Oxford University Press), pp. 512–57

———. 2016. ‘The Scientific, the Literary, and the Popular: Commerce and the Reimagining of the Scientific Journal in Britain, 1813–25’, *Notes and Records of the Royal Society*, 70: 305–24

Topp, Leslie, James E. Moran, and Jonathan Andrews, eds. 2007. *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (New York: Routledge)

Topp, Leslie. 2018. ‘Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums, 1838–1844’, *Social History of Medicine*, 31: 754–73

Turner, Trevor. 1991. ‘“Not Worth Powder and Shot”: The Public Profile of the Medico-Psychological Association, c. 1851–1914’, in *150 Years of Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 3–16

Twine, Richard. 2002. ‘Physiognomy, Phrenology and the Temporality of the Body’, *Body & Society*, 8: 67–88

Van Wyhe, John. 2004. *Phrenology and the Origins of Victorian Scientific Naturalism* (Aldershot: Ashgate)

Waddington, Ivan. 1973. ‘The Role of the Hospital in the Development of Modern Medicine:

A Sociological Analysis', *Sociology*, 7: 211–24

———. 1984. *The Medical Profession in the Industrial Revolution* (Dublin: Gill and Macmillan Humanities Press)

Walbaum, Sharlene D. 2019. 'The Invisible Woman: Susan Carnegie and Montrose Lunatic Asylum', *History of Psychiatry*, 30: 409–23

Walkowitz, Judith R. 1992. *The City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (London: Virago Press)

Walmsley, Tom. 1991. 'Psychiatry in Scotland', in *150 Years of Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 294–305

Wallis, Jennifer. 2017a. 'Bloody Technology: The Sphygmograph in Asylum Practice', *History of Psychiatry*, 28: 297–310

———. 2017b. *Investigating the Body in the Victorian Asylum: Doctors, Patients, and Practices* (Cham: Palgrave Macmillan)

Walmsley, Tom. 1991. 'Psychiatry in Scotland', in *150 Years of Psychiatry, 1841–1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell), pp. 294–305

Walton, John. 1981. 'The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816–1870', in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. by Andrew Scull (Philadelphia: University of Pennsylvania Press), pp. 166–200

Wannell, Louise. 2007. 'Patient's Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875–1910', *Social History of Medicine*, 20: 297–313

Weatherall, Mark. 2000. *Gentlemen, Scientists and Doctors: Medicine at Cambridge 1800–1940*, History of the University of Cambridge Texts and Studies, III (Woodbridge: Boydell Press in association with Cambridge University Library)

Weiner, Dora. 1991. 'Mind and Body in the Clinic: Philippe Pinel, Alexander Crichton, Dominique Esquirol, and the Birth of Psychiatry', in *The Languages of Psyche: Mind and Body in Enlightenment Thought*, ed. by G. S. Rosseau (Berkeley: University of

California Press), pp. 331–403

———. 2000. ‘Betrayal! The 1806 English Translation of Pinel’s *Traité médico-philosophique sur l’aliénation mentale ou la manie*’, *Gesnerus*, 57: 42–50

Weiner, Joel H. 1988. ‘Introduction’, in *Papers for the Millions: The New Journalism in Britain, 1850s to 1914*, ed. by Joel H. Weiner (New York: Greenwood Press), pp. xi–xix

Weiss, Kenneth J. 2012. ‘Psychiatry for the General Practitioner: Isaac Ray’s Jefferson Lectures, 1871 to 1873’, *Journal of Nervous and Mental Disease*, 200: 1047–53

Weisz, George. 2006. *Divide and Conquer: A Comparative History of Medical Specialisation* (Oxford: Oxford University Press, 2006)

———. 2003. ‘The Emergence of Medical Specialization in the Nineteenth Century’, *Bulletin of the History of Medicine*, 77 (2003), 536–74

Whiteley, Rebecca. 2019. ‘Figuring Pictures and Picturing Figures: Images of the Pregnant Body and the Unborn Child in England, 1540–c.1680’, *Social History of Medicine*, 32: 241–266

Whyte, William. 2015. *Redbrick: A Social and Architectural History of Britain’s Civic Universities* (Oxford: Oxford University Press)

Winter, Alison. 1998. *Mesmerised: Powers of Mind in Victorian Britain* (Chicago and London: University of Chicago Press)

Wright, David. 1997. ‘Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century’, *Social History of Medicine*, 10: 137–55

———. 1998. ‘The Certification of Insanity in Nineteenth-Century England and Wales’, *History of Psychiatry*, 9: 267–90

———. 2001. *Mental Disability in Victorian England: The Earlswood Asylum, 1847–1901* (Oxford: Clarendon)

Wübben, Yvonne. 2016. ‘La formation du regard clinique’, *Revue d’histoire des sciences humaines*, 29: 149–73

York, Sarah. 2011. ‘Alienists, Attendants and the Containment of Suicide in Public Lunatic Asylums, 1845–1890’, *Social History of Medicine*, 25: 324–42

Zilboorg, Gregory. 1941. *A History of Medical Psychology* (New York: Norton)