FROM POISON PEDDLERS TO CIVIC WORTHIES: THE REPUTATION OF THE APOTHECARIES IN GEORGIAN ENGLAND

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FROM POISON PEDDLERS TO CIVIC WORTHIES: THE REPUTATION OF THE APOTHECARIES IN GEORGIAN ENGLAND

'This is the *mere* Apothecary - a Creature that requires very little Brains', reported *The London Tradesman* sardonically in 1747. And, for a while, the occupational handbook continued in the same vein:[1]

> *There is no Branch of Business in which a Man requires less Money to set him up, than this very profitable Trade: Ten or twenty Pounds, judiciously applied, will buy Gallipots and Counters, and as many Drugs to fill them with as might poison the whole Island.*

Here, plainly enough, was the classic representation of the 'poor apothecary' as a low-grade dispenser of risky medical pharmaceutics. The account invokes the popular suspicion of poisonous pills and exotic potions that cost large sums for uncertain gains. 'I felt unwell – I resolved to get better – I took medicine – I died', ran an old joke. Whether everyone agreed with such hostile comments is unknown but certainly *The London Tradesman* felt no compunction in rehearsing them uncompromisingly.

Robust as were these public comments, however, they were being gradually challenged, in the course of the eighteenth century, by an alternative rhetoric of medical enlightenment. Doctors were actively engaged in trying to establish a shared and tested infrastructure of theory and practice. That process raised them in public esteem and eventually allowed them to define the boundaries of their business, by outlawing the untrained quacks. In the eighteenth century, there was no clear-cut division between an 'ordinary' occupation and a formalised profession, defined by access to special training, qualifications, and command of specialist knowledge.[2] Particularly in medicine, there was absolutely no

rigid line dividing an untrained 'quack' from a respectable healer.[3] However, the terminology and concept of an organised 'profession' was gradually emerging, and the apothecaries' redefinition of their own role was part of that process.

That things were changing was indicated by the same occupational handbook that has already been cited. Traditionally, an apothecary's core business was the making and vending of medicinal drugs. But the 1747 text reported a significant development:

> *The Army of Apothecaries of this Age scorn to confine themselves to the dull Scene of their [pharmaceutical] Profession: They are no sooner equipped with a Shop than they commence Doctor*.[4]

In other words, they were treating patients. The widening use of the title of 'Doctor' was itself a sign that recognition was being accorded to the functional medical prescriber rather than reserved for the formally qualified University graduates. Bold charlatans as well as careful practitioners used the title, with the market as the ultimate check of each one's relative success or failure. Hence many of the campaigns for subsequent reforms of medical training and practice came from conscientious apothecaries who were aware that the free-for-all had serious shortcomings.

On the other hand, these practitioners did not deserve the total condemnation that has recently been pronounced by the historian David Wootton. He argues that, before the scientific understanding of antiseptics in the mid-1860s, all 'doctors, trying hard to save lives, went around killing people'.[5] Such a sweeping verdict echoes the jests of the eighteenth-century satirists, who regularly lampooned the faults and foibles of the professions. And it is undeniable that many medical treatments could have been improved and many patient deaths postponed, had doctors then had access to the medical and scientific knowledge that

have become available to later generations. But such a proviso is anachronistic and unhelpful.

The black view of all doctors as 'killers', moreover, makes it impossible to understand why people sought their assistance and how a respected profession emerged to undertake and share the research that gradually transformed medical practice. Caring for the sick and dying is a deeply socialised process as well as a technical one. That has been abundantly demonstrated by the pioneering research of Roy Porter,[6] and by the seminal studies of the medical rank-and-file by Digby, Loudon, and Burnby.[7] It is also rightly stressed by historians such as Margaret Pelling, that there was no linear highway marked as inevitably leading either to 'progress' or to professional institutionalisation (the two outcomes, of course, not being considered as identical). Indeed, most recent historiography is sceptical of rosy mythologies and points instead to immediate contingencies rather than to inexorable trends. The institutional divorce of the Surgeons from the old Barber-Surgeons Company in 1745, for example, was motivated by Parliament's desire to supply of medical specialists for the British navy, rather than by a conscious promotion of professionalisation.[8] Hence rejecting the sternly critical view does not require a return to an unduly rosy one.

Building upon these insights, the discussion here re-analyses the apothecaries' role and experiences as they were gaining their collective position as embryonic professionals. That process merits attention, whether or not the historian approves of the ultimate trend. The process was a slow one, and the subtle momentum of gradual transition is often hard to detect. Yet it still has a history, which explains why contingent choices, when they are made, take place in the specific form that they do. The transformation of the trading apothecaries into medical professionals

is analysed in terms of firstly, the intersection between medical supply and insistent consumer demand; secondly, the intersection between local power-broking within Britain's growing towns with an ethos of community service; and, lastly, the intersection of shared knowhow, including new treatments, with a cumulative momentum in support of professional demarcation and training. The chief sources are publications by eighteenth-century apothecaries, as they presented themselves for scrutiny in the burgeoning medical market-place in print;[9] plus any other resources relating to their public presence, such as medical registers and urban records. Collectively, the outcome demonstrates the intricacies of a classic case of micro-change.[10]

I: Responding to Consumer Demand

Throughout the period from the later seventeenth to the early nineteenth centuries, there was a chronic under-supply of the elite physicians in comparison with the pressures of insistent consumer demand, which always tends to outstrip medical provision. Ill people continued to apply self-medication and to garner advice from friends, family and across-the counter medical vendors, as people do to this day. But they also sought personalised attention for their maladies, both major and minor, from professional service suppliers. The attendance of a doctor at the death-bed scene was becoming more common, accompanying the traditional presence of the clergyman. Moreover, it was not uncommon for affluent families to consult more than one medical practitioner at a time.[11] They wanted care as well as cure.

As a result, the market for such services was highly competitive. The expanding economy was providing a growing range of specialist professions and simultaneously to generate the critical mass of reasonably

affluent consumers with the demand to match the supply.[12] Pressurised by circumstances, the traditional threefold demarcation within the medical profession was subject to continual erosion. In theory, the high-ranking physicians undertook the delicate art of diagnosis. They were University-educated and hence, in this period, Anglicans to boot. Next in the traditional rankings came the surgeons, who did the bold and bloody tasks of operating upon the body, and, at the foot of the hierarchy, came the 'mere' apothecaries who made and dispensed medicines.

Few patients, however, were concerned with these demarcational proprieties; and many poorer families were unable to pay the physicians' costly fees. So the unregulated medical market quickly tugged the apothecaries into diagnosing and treating as well as providing the medicines. The older tradition of the learned physician, treating his patients as much from his deep knowledge as from the prescribing of pills and potions, was being replaced by a much more empirical and experimental culture. A 1697 playlet *Physick Lies A–Bleeding* noted the trend. In it, a medical grandee grumbles that: 'Every ignorant Apothecary assumes the Cure, and pretends to know more than the learned'st Physician of us all'.[13] The upstart cares nothing for the claims of abstract book-learning and lofty University degrees.[14] He is named Dr Pestle, as a mark of his craft, and he is ready to supply the avid patients with the direct remedies for which they clamour. So he confides slyly: 'I myself have turn'd … several Doctors [Physicians] out of Families, because they would not prescribe Physick *plentifully*, and in large Quantities.'

Indeed, a crucial legal decision in 1704 confirmed the erosion of the traditional demarcations. It followed a test case involving a London apothecary named William Rose. He lost the first round of his claim to prescribe as well as to dispense medicines, when the judges in King's

Bench found against him. Upon appeal to the House of Lords, however, Rose won as famous victory.[15] Apothecaries were henceforth free legally, as *de facto* they were already becoming in practice, to act as all-round doctors, providing the full gamut of professional care. In many ways, therefore the old divisions were dead – yet they survived in the institutional forms that guided the profession, hence leaving the apothecaries still to combat perceptions of their relatively lowly status.

Public criticisms of their abilities were never stilled, even by the legal ruling in the Rose case. The eighteenth century was notoriously a period of vigorous medical claim and counter-claim, when accusations of quackery were readily invoked. Individual apothecaries responded to defend their all-round expertise. 'Why are we [apothecaries] branded with the Opprobrious Names of *Quacks, Mountebanks, Empiricks* and what not'? demanded one polemicist.[16] Instead, the title of his 1704 tract explained the *Reasons why the Apothecary may be Suppos'd to Understand the Administration of Medicines in the Cure of Diseases as well as the Physician.* Another polemic underlined the message in 1739. Proudly, its title averred: *One Physician is e'en just as Good as T'other; And Surgeons are not less Knowing, Apothecaries as Good as Any - if not Best of All.*[17]

A number of the more eminent drug-dispensers had obtained a formal apprenticeship. But other apothecaries, before the later advent of regulation in 1815, simply set up shops on their own account, with the compounding and vending of drugs as the bread-and-butter of their business. Again in 1747 another guide to contemporary occupations noted the trend. 'This [the apothecary's] is a very genteel Business and has been in great Vogue of late years'.[18] One mid-eighteenth century exemplar was John Allen. He became the official Apothecary to the first three

Hanoverian monarchs and he amassed an ‘ample fortune’, leaving upon his death in 1774 substantial legacies to charity.[19] Of course, far from all practitioners enjoyed such patronage and such success. The doctor was a god to be idolised when people were ill, ran an old saying, but a devil to be shunned once the fee was due.[20] The apothecaries, as the medical rank-and-file, were used to the scramble to collect payment, especially from poorer patients. It was customary to extend credit, but the practitioner carried the risk. For example, one Henry Fogg, a Staffordshire apothecary who died prematurely in 1750, was owed money at his death by over 200 patients, both in the market-town of Leek and throughout the surrounding countryside, with a number marked as unrecoverable ‘bad debts’.[21]

Yet there were enough conspicuous success stories to alter public perceptions. The stereotypical ‘poor apothecary’ of Shakespearian fame was being transformed into the new money-spinner, again in stereotype. The unfortunate Henry Fogg in his lifetime had a house in Leek that was comfortably furnished and contained a considerable array of medical books.[22] And public opinion was increasingly tending to take a rosy view of the level of remuneration that practitioners were getting. So Adam Smith for one noted in 1776 that the ‘Apothecaries’ profit is become a by-word, denoting something uncommonly extravagant’. For him, however, such success was fully justified. As an apothecary’s reputation was based upon his professional abilities as well as his potions, Smith argued that: ‘His reward, therefore, ought to be suitable to his skill and his trust’.[23]

Many individual medical men relied upon word-of-mouth recommendation from satisfied patients. A proportion also used the power of advertisement in the burgeoning eighteenth-century press.[24] For example, in 1777 one Francis Spilsbury offered special Anti-Scorbutic Drops ‘for the radical cure of *Scurvy, Gout, Rheumatism, Evil [scrofula]*,

Children's Eruptions, Ulcers, Leprosy, Nervous Complaints, Humours after the Smallpox and Measles, etc'. Supporting testimonials from patients and from apparently disinterested witnesses were supplied as additional inducement to buy.[25] This medicine, however, had absolutely no scientific standing and may have been simply an opiate.

Such examples indicated the dangers in the free-for-all provision of medicinal remedies, in the absence, before 1868, of any statutory controls on the provision and sale of drugs.[26] The unknown quantity of most of the eighteenth-century potions makes it hard to give any retrospective assessment of their merits.[27] It is known that some remedies, given in good faith, were positively harmful, such as the standard use of the mercury cure for venereal diseases. Questioned in the nineteenth- and abandoned in the twentieth century,[28] this was actually a toxic remedy.

Nonetheless, the judgment of history, however interesting for later assessments of diachronic change in medical treatments, was irrelevant to eighteenth-century patients. They tended to believe in the remedies offered to them. Indeed, reputable medical men worried that people were too credulous and superstitious for their own good, leaving them vulnerable to quacks.[29] In fact, there was a standard range of herbal and other remedies in the eighteenth-century pharmacopia or *Materia Medica*.[30] And these treatments combined a medley of tradition and novelty, as they often do.[31] Among the new resources available were opiates for pain control (which were useful if risky) and the growing volume of imports from overseas sources, including quinine - cinchona or Peruvian bark - for combating malaria (which was genuinely effective).[32]

Growing numbers of medical practitioners described themselves as surgeon-apothecaries or as surgeons *and* apothecaries, providing the bedrock of working doctors. Indeed, this convergence is saluted to this

day in the naming of the general practitioner's consulting room as the 'surgery'. Significantly, the cumulative impact of reputational change can be seen in the emergence of a new terminology in the early nineteenth century. In 1818 the rank-and-file surgeon-apothecaries were first dubbed as the nation's 'general practitioners' – at a date much earlier than commonly thought.[33] The novel phrase gained further currency over the following decades, with two text-books using the term in 1845; and, of course, it remains in use today. The old apothecary was thus subsumed into the very bedrock of the profession.

II: Becoming Civic Worthies

One major contributing factor in their rising reputation was their entrenchment not only in the sickrooms of private homes but also in the public power structures in the localities. The process was already apparent in the 1690s and accelerated thereafter. It applied particularly in the towns, where professional services were often concentrated – and where they were particularly visible. Medical history was thus an integral part of urban history – and *vice versa*. Although traditionally the 'civic worthies' were drawn from the ranks of merchants, traders, and manufacturers, in this period their numbers were augmented by the emergent professions – notably the clergy, lawyers and doctors. Sometimes, these urban leaders relied upon the discreet patronage of an aristocrat or landed gentleman with estates nearby. It helped a 'coming' young apothecary to have good connections and patrons not only among his immediate neighbours but also among the surrounding county society. Yet the town-country relationships were dynamic ones, in which the civic interest was far from subservient.

London was a particular hotspot for the congregation of medical

men, matched, in Scotland, by Edinburgh which was one of the great pioneer cities for the hospital training of young medical men. Another significant location was the booming resort of Bath, where people took the 'cure' by drinking or bathing in its hot springs. Not surprisingly, that city had more medical men in residence than it did lawyers. The imperfect but indicative *Bath Directory* in 1787 named 34 prominent doctors there, compared with only 15 attorneys.[34]

Within the profession, the old rankings by no means disappeared. The three *Medical Registers* that were produced commercially between 1779 and 1783 began their listings with the names of the eminent physicians. However, by this date the 'surgeons and apothecaries' (jointly named) had become the most frequently occurring designation. In the city of Norwich, for example, the 1783 *Norwich Directory* named 26 doctors practising locally, whose numbers included six physicians and twenty surgeon/apothecaries. Listings such as these conferred public visibility upon the reputable practitioners, while disreputable quacks were excluded. Together, the combined medical ranks constituted a veritable 'republic of Physic', as one anonymous practitioner urged his fellow-practitioners in the 1780 *Medical Register*.[35]

Civic 'worthiness' was clearly demonstrated by election to the prestigious post of Mayor or its equivalent. In eighteenth-century Norwich no physician gained that title (though they did in earlier and later periods).[36] Instead, the medical leader in the urban politics of these years was a second-generation apothecary, John Pell, Mayor in 1730, who was later followed by a surgeon as Mayor in 1785. Another notable example was William Cogan in Kingston upon Hull. He was an apothecary and philanthropist, who became Mayor in 1717 and again in 1736, when he endowed a charitable school for poor girls. This record

was nonetheless out-trumped by William Franceys in Derby. He became Mayor in 1697, 1699, and 1700; and his son Henry Franceys, also an apothecary, followed in his footsteps. It is notable that the elevation of such men occurred early as well as late in the eighteenth century, showing that local reputation was readily out-trumping traditional prejudices.

None of these places had special reasons for having a strong medical presence: but all generated sufficient demand to sustain a successful practice. In a spa and resort city like Bath, it was not surprising to find a stream of apothecary-Mayors.[37] Their aggregate numbers everywhere were still much smaller than those of the merchants and dealers who habitually sought the Mayoralty. But examples were found in small towns as well as large. Thus Brecon was the residence of the apothecary Bartholomew Coke who twice became Bailiff (Mayor), while the great dockyard headquarters of Portsmouth produced the powerful figure of Edward Linzee. He was an apothecary-surgeon, who held the Mayoral office frequently. His daughter Susannah rose still further, marrying the successful Admiral Samuel Hood, whose career was first advanced by her father. Later, she was awarded a peerage title as Baroness in her own right and saw her husband become a Viscount. The rise of the Linzee family was a pertinent reminder that both the navy and the army were notable sponsors of medical men,[38] especially in the great dockyard towns. Interestingly, too, many local leaders in the American colonies' revolt against Britain were medical practitioners who were used to local and civic leadership.[39]

Becoming established within town societies strengthened the prestige of the profession. Urban power-broking acknowledged the civic 'arrival' of the apothecaries, who were accordingly more active in such municipal roles in the eighteenth century than the already-dignified

physicians.[40] All medical practitioners, of course, had a common interest in cultivating an authoritative presence and clear judgement. So individual apothecaries did not hesitate to trumpet their claims. In a 1728 comic squib entitled *Like will to Like, as the Scabby Squire said to the Mangy Viscount*, one announced that: 'The Profession I have been bred to, and which I thank God I for many Years [have] practis'd with Reputation, has led me to see Things as they really are, and to form an Opinion accordingly.'[41] An urbane discretion was *de rigueur*. 'The less a medical man talks the better and that should always be to the purpose', advised a handbook in 1820.[42] And satirists chastised those who fell below the ideal. Thus a squib from Dublin in 1726 joked that community 'embeddedness' could go too far, with *An Excellent New Ballad, Showing how Mr Mordecai Adams, Apothecary of Dublin, was Catch'd in Bed with Two Sisters.*[43] Whether this text was a spoof or recounted a real intrigue is unknown, but such diatribes indicated that medical men were public figures and expected to behave as such.

Supporting philanthropic 'good causes' was one effective means of gaining social credit while hoping simultaneously to enhance medical welfare. Many apothecaries joined their fellow practitioners in promoting local hospitals, sick-rooms in urban workhouses, and dispensaries to provide free medicines for the poor. Such initiatives were more common in larger towns than in smaller places, but they implied that health-care everywhere was potentially a good for all. Civic-minded medical men gave free consultancies, in a medical version of *pro bono publico*. For example, the Lincoln Hospital (founded 1769) was attended *gratis* by a physician and five surgeons in monthly rotation, as well as by two apothecaries, who supervised the Hospital's one salaried apothecary.[44]

How widespread such unpaid commitment was in reality is

impossible to ascertain. It was sufficiently common, however, to become a matter of professional pride. So one Birmingham apothecary reported confidently in an open *Letter* (1739) that:

> *I never knew any one either of the late or present Physicians in Town or Country refuse their Advice and Assistance to poor People, or Servants,* Gratis*; and I believe every Apothecary in Town can say the same.*[45]

Charitable activities further boosted the prestige of the medical profession, even while individual practitioners may well have gained extra business through their participation. A tract in 1844 suggested knowingly that doctors undertook 'good works' for interested rather than disinterested reasons.[46] The innuendo was an anticipation of George Bernard Shaw's later critique of all the professions as 'conspiracies against the laity'.

Nevertheless, giving free services to the poor took time and attention that might otherwise have been devoted to fee-paying patients. As a result, there was – alongside the satire - a rival perception that the medical profession was 'caring' and civic-minded. Charitable practitioners, who gave their services *gratis*, were 'thus good and kind, tho it be to their own hindrance', as a clergyman declared in a 1777 sermon in celebration of the Gloucestershire public infirmary.[47]

An example of a real-life local worthy exemplified the public reception of medical merit. The Norwich surgeon-apothecary, Mr Greaves, both supported and worked for the new Norfolk and Norwich Hospital, founded in 1770. To that institution he donated, on his deathbed, his entire medical apparatus.[48] The Greaves Bequest of 1779 comprised: two sets of surgical instruments; a leather case for the said instruments; one sharpening stone; one steel bucket for sterilising the instruments in Greaves's special mixture of water and herbs; a supply of linen; a

medicinal herbiary; one top hat - and one frock coat, 'stiffened by constant soaking from blood and pus'. Tools and insignia such as these were marks of a working meritocrat – an active, busy professional, who gained kudos by 'doing' rather than just 'being'. Greaves's claim to status was apparent in his habitual wearing of a black frock coat and a top hat. These were the outward signs of an urban gentleman. The 'blood and pus' on his coat, meanwhile, were pledges of medical verisimilitude, since he wore this attire when operating. Admittedly, in the light of later knowledge, this was hardly best practice; but in his own day Greaves was much respected, as the trustees signified by putting his Bequest on show.

Rhetorical confidence in the profession's benevolent contribution to community welfare was loudly voiced. In 1799, for example, the Prince of Wales's official Apothecary designated the study of medicine as a 'liberal science', whose practice was 'most enlightened'.[49] The mantra became something of a platitude in the following decades. A routine essay on the 'General Practitioner' (1823) invited young men to enter an occupation that was not necessarily well paid but that had the merit of 'soothing the distresses and alleviating the sufferings of mankind.'[50] And the same credo recurred in a handbook for neophyte doctors in 1820: 'A medical gentleman should always bear in his mind *this motto*, "that he is the servant of the public".'[51]

Particularly important among the business of the rank-and file surgeon-apothecaries was attendance upon women in childbirth. During the eighteenth century, this natural process became increasingly medicalised. The new fashion for 'men-midwives' with their new surgical implements spread fast among well-to-do families,[52] although female midwifery long remained the chief recourse for the indigent. A coloured aquatint from 1827, entitled the *Surgeon-Apothecary summon'd to a*

*Night-Call** shows a classic scene. The sleepy practitioner who lives above his apothecary's shop is roused by a late call for an *accoucheur* (the status-conferring title for a man-midwife), as the cat and flower-pot go flying. The routine is familiar, just as he is a familiar figure in his urban parish and at client's bedside. He is at once a man of power and a man called to service. Soon he will grab his medicine bag and hurry out into the night.

III: Generating a Profession

For the serious-minded medical practitioner the pooling of information, experimental results, and systems of classification was particularly important, as well as the sharing in professional debates. Such elements of cooperation had occurred in earlier eras,[53] and continued to multiply during this period. It was becoming the mark of a quack to vaunt a 'secret' or 'magical' nostrum, while a reputable healer should be ready to share expertise with others. Dispensing apothecaries accordingly circulated circulating information about drugs and their usages.[54] On their travels, they would also visit the famous herb gardens belonging to their green-fingered colleagues.

When travelling to London, there was one special attraction. The Society of Apothecaries, which represented the metropolitan elite among this branch of the profession, had its own celebrated Physick Garden beside the Thames at Chelsea. It was then the showcase for medicinal herbalism. Delicate and exotic plants were displayed in an impressive glass-house, built in the mid-1730s following a substantial bequest from John Brownell, a wealthy London apothecary.[55] Only later, in the nineteenth century, did the Physick Garden lose its lustre, as the encroaching metropolitan sprawl began to degrade the local

environment,[56] and as new chemical drugs were being pioneered.

Competition and personal rivalries were, of course, far from unknown, as practitioners jockeyed for their share of the medical market. 'Envy, malevolence, and other illiberal dispositions towards their brethren' are hallmarks of the profession, claimed a candid doctor in the 1780 *Medical Register.* Nonetheless, groups with a common interest often contend among their own ranks, whilst displaying solidarity vis-à-vis the wider world. Such a state of rivalrous professionalisation was becoming manifest in the course of the eighteenth century, when some doctors were attached to institutions like Hospitals but most competed in the medical market-place. This mixture of jostling and sharing was later depicted in George Eliot's great novel of provincial urbanism, *Middlemarch.* The ambitious young practitioner, Tertius Lydgate, struggles to establish himself against two entrenched seniors. But he still conducts experiments in his spare time, hoping to contribute to scientific knowledge. He muses ardently, early in the tale: 'There is nothing like the medical profession for that'.[57]

No doubt, in real life busy practitioners found it hard to find time for such efforts, as did Lydgate in the unfolding of Eliot's novel. Nonetheless, the aim was boldly civic as well as personal. Medicine is 'the science which proposes the noblest object for its end, the preservation and restoration of health', announced the Quaker Dr Lettsom in 1773.[58] He himself made a fortune from doctoring, having begun as an apprentice to a surgeon-apothecary before rising to the front ranks of the physicians. Confident in his own abilities, he then published tracts to expound his views on matters pharmaceutical, medical, moral, and philanthropic.

Among other things, Lettsom in 1801 urged people to trust the

novel technique of cowpox vaccination, as a preventive and palliative measure against smallpox. It would, he enthused, introduce 'a new aera in practical medicine, and a new source of human felicity'.[59] Here Lettsom was right in identifying signal development. For many years, surgeon-apothecaries had offered the older technique of inoculation, learned from the Turks and introduced into Britain, with some controversy, in the 1720s. It became increasingly widely adopted because it was observed, empirically, to have some success in reducing the virulence of smallpox, long before there was a scientific understanding of the smallpox virus.[60] This development encouraged the hope that a particularly feared and disfiguring disease could eventually be eradicated (as was done, world-wide, two hundred years later).[61] Even Wootton is prepared to give some grudging praise to this element of pre-nineteenth-century medicine.[62] By sharing good practice, medical practitioners were able to act, ahead of a full scientific understanding. It was within that experimental tradition that Edward Jenner, who began his career as an apprentice surgeon-apothecary, refined his vaccination process in 1796.[63] Not only did he quickly inform the world of his systematised discovery but his medical peers were as quick to realise its significance, even while aspects of his technique and remained to be debated and refined.

Doctors kept in touch with the latest news via informal informational grids, sustained by the letters, journals, meetings, gossip, and chitchat that generate professional *communitas.* One regional organisation, founded in Canterbury in 1787, provided an example of group solidarity in action. It was a Benevolent Medical Society, established to assist the widows and orphans of all physicians, surgeons *and* apothecaries throughout the county of Kent.[64] All its members gained a mutual reassurance that, in the event of their premature deaths, their

families would not be left in financial distress.

Solidarity within the emergent profession was also encouraged by the local medical clubs and societies that sprang up in the larger towns across late eighteenth-century Britain. These voluntary associations were ecumenical in their membership, excluding the druggists who merely sold drugs but including all practitioners from apothecaries to physicians.[65] Ideas were shared in an atmosphere of collegial sociability, as indicated notably by the Gloucestershire group, co-founded in 1788 by Edward Jenner, and named as the Medico-Convivial Society.[66] In addition to these informal networks, the expanding number of teaching Hospitals in London, Oxford, and other cities, provided institutionalised bases for professional cooperation, as they recruited both specialists and generalists.[67]

Linkages were also fostered over time. All the professions tended to recruit particularly strongly from within their own ranks, with sons following fathers in their choice of occupation. In the eighteenth century, this pattern was already apparent. There were several father-and-son medical dynasties, either following in the same branch of medicine, or, in the case of ambitious sons, upgrading into the 'higher' ranks. One of Dr Johnson's friends from his home-city of Lichfield makes the point. He was the apothecary Richard Greene, with his locally-famous museum or 'cabinet of curiosities'. He became sheriff, alderman, and twice bailiff of Lichfield. And two generations later his grandson Richard Wright was practising in the city but as a surgeon.[68] This matched the experience of other professions, when sons of attorneys became barristers, or sons of parish clergymen were promoted to become bishops. The internal hierarchies of status remained but within one overarching profession.

Medical families, furthermore, tended to intermarry. To take one

example of many, Thomas Denman was an apothecary's son who became a famous man-midwife in later eighteenth-century London. Both his daughters married men who became prominent physicians, though his only son broke ranks to train instead as a lawyer.[69] Meanwhile, those who did not marry strictly within the profession still tended to find marriage partners among the offspring of legal or clerical families. In this way, an entire professional milieu was emerging, within a heterogeneous middle class with its rival commercial and professional interests.[70]

Public awareness of the reputable medical men across England and Wales was further heightened in the 1780s by the availability of published listings. These were produced commercially in the three years between 1780 and 1783 and were unlikely to have been completely accurate. Some practitioners may not have been listed, while others who were listed may have ceased to practice. Nonetheless, the publication signalled a contemporary view that these men were different from the legions of quacks and patent medicine vendors. In detail, the listings confirmed that most of the eighteenth-century growth of the medical profession was based upon the expanding numbers not of the elite but of the workaday practitioners. 'In this city [London], where a physician attends one patient, an apothecary attends twenty; and, in the country, this proportion is more than doubled', claimed the apothecary's advocate John Mason Good in 1795.[71]

Across the country, Good's general point can be confirmed. The 1780 *Medical Register* revealed that, in two regional examples, East Anglia enjoyed the services of 7 surgeon-apothecaries (86.4% of the recorded total) for every 1 physician (12.6%) – while in the northern countries of Durham and Yorkshire the same proportion obtained. [See Table 1 below] The close correspondence between the two areas, in terms

TABLE 1: MEDICAL PRACTITIONERS IN TWO ENGLISH REGIONS 1780

	Physicians	Surgeon/ Apothecaries	Druggists	TOTAL
EAST ANGLIA (Essex, Norfolk, Suffolk)	38 (12.6%)	261 (86.4%)	3	302
DURHAM/YORKSHIRE	43 (14.0%)	263 (86.0%)	-	306
TOTAL	81	524	3	608

Source: *Medical Register*, 1780, pp. 90-4, 122-5, 147-9, 158-65

of the types of medical help available, was striking. And, even more notably, a very similar ratio was revealed by the 1851 census, seventy years later. Again the apothecary-surgeons outnumbered the elite physicians, then by a ratio of 7.5 to 1.[72]

TABLE TWO: MEDICAL PRACTITIONERS *PER CAPITA* IN TWO ENGLISH REGIONS, 1780

	All Practitioners	Estimated population	Medical Practitioners *per capita*
EAST ANGLIA	302	603,260	1 per 1998
DURHAM.YORKSHIRE	206	911,420	1 per 2978

Sources: All practitioners as in Table 1; plus population estimates, based upon a comparison of 1750 county populations in Young 1786-1808 with British census returns 1801.

Comparison of the number of medical practitioners with the size of the locally resident population, however, reveals that the total coverage varied considerably from location to location. The availability of practitioners was greatest in the south and east, and sparsest in the north and west. In 1780, there was 1 doctor (counting all apothecaries, surgeons and physicians together) in Durham and Yorkshire for approximately

every 3000 inhabitants, while in East Anglia, the ratio was 1 to 2000 (see Table 2). The division between north and south was, however, not absolute in practice, as people also travelled – for example to Bath or London – for medical consultations.

Furthermore, pharmaceutical remedies could be shared across regions, as indeed the drugs trade was already developing in earlier eras.[73] In 1750 one handbill advertisement, aimed at sufferers from 'Convulsions and Hysterick Fits; … Vapours; and all Disorders proceeding from weak Nerves', touted a patent remedy devised by a Doncaster apothecary named Perkins.[74] Its medical efficacy was unknown. Nonetheless, its inventor clearly hoped for more than local sales. So his customers were advised to visit a London druggist, who stocked the Doncaster remedy. **However,** cure-alls such as these increasingly worried respectable practitioners. One London apothecary, identified only by the initials P. L., noted severely in 1752 that: 'in almost all Diseases these Things [pills and potions] are cried up as if they were divine, by such as have made a Trade of these Trifles, to the great Dishonour of the Profession of Physick'.[75]

Reform was, however, not easily won. Their historic divisions, sustained by their separate institutions, kept the different branches of medicine officially apart. Thus the surgeons in 1748 and the physicians in 1758 pointedly excluded the up-and-coming apothecaries from joining their specialist Companies.[76] Those decisions did not, however, halt the medical 'juniors'. The London Society of Apothecaries in this period never sought to enrol all dispensers and practitioners. But, with some 350-400 members active at any one time in the eighteenth century, it flew the flag for medicine's 'pharmaceutical branch'. It was heavily London-based, with members like Mr Uppington Bracee (1736), whose name

alone seemed to promise recovery. Nonetheless, some had moved to provincial practices. In September 1752, for example, the Yeomanry – the lowest tier of membership - included Thomas Arnold in Bicester, Staniford Blanckley in Portsmouth, Thomas Dance in Salisbury, Theophilus Greene in Chelmsford, and Richard Pratt in Winchester.

While therefore the Society's writ was technically confined to the city of London, practically it was able to assume a wider remit. It was assisted in that by the nature of its membership. Most of other London livery companies in the eighteenth century were no longer recruiting from those who worked in the specific business that had first launched each company as a medieval trade guild. But the Apothecaries Society continued to recruit practitioners. Only a few were listed as having 'left off the Trade' (using the old phraseology of commerce). Moreover, among the activists, the growing predominance of the medical practitioners over the drug dispensers was strikingly confirmed in 1774, when it was resolved that the Liverymen (the elected upper tier of the membership) should be recruited solely from medical practitioners.[77] Not only was this a highly significant decision – but it was one that was upheld.

Incidentally, in 1727 the Society of Apothecaries rejected an application for membership from a Mrs Read, an apothecary's daughter who claimed admission by right of patrimony and was probably running the family business.[78] But in the eighteenth century such cases were rarely successful. (The few women dress-makers in York who joined the York Merchant Tailors' Company remained minor figures in both the York economy and its guild life).[79] Of the London apothecary Mrs Read, meanwhile, nothing more is known. Her request constitutes a quiet reminder that many eighteenth-century women provided health care as

nurses, midwives, healers, and herbalists. Yet they were then excluded from the institutional organisations and most official records. The lone female in the 1780 *Medical Register* was one Mrs Mason, a Norwich druggist. In 1783, however, the 1783 *Norwich Directory* noted her business simply as 'Mason & Tidd'.

Defending the interests of their collective business thus made the male apothecaries at once radical when challenging the elite physicians but conservative when challenged themselves. In the later eighteenth century, they were indeed facing fresh competition on a new front. Such was the demand for pills and potions that, as the apothecaries had become medical practitioners, others trading as chemists and druggists were entering into the business of selling commercial remedies over the counter. Mrs Mason of Norwich was one of these. It is not known what proportion of all apothecaries were still making and dispensing drugs, as they had done at the start of the century. Probably some numbers of those who did not make the transition to medical practitioners, or who tried and failed, became known as druggists instead. That left the apothecaries with the reputation as medical practitioners.

Thoughtful leaders among their ranks expressed anxiety over the prevalent free-for-all. 'Ignorance must, of necessity, be a source of evil in every profession', stressed the apothecary John Mason Good sagely, 'but of all professions it is most to be dreaded in that of medicine. A single error may here produce death …'.[80] In 1795 he accordingly co-founded the General Pharmaceutic Association of Great Britain, to campaign for proper training and regulation.[81] Moreover, the case for reform was highlighted by an early nineteenth-century survey of medical practice in four districts of northern England. Only 1 in 4, among a total of 266 practitioners, had received any formal training and qualification.[82] The

others had learned ‘on the job’.

Eventually, the persistence of the reform-minded apothecaries won a response from Parliament. The elite medical institutions, the Royal Colleges of Physicians and of Surgeons, held aloof. But in 1815 the Society of Apothecaries was licensed by statute to establish a professional system of education, examination, and registration.[83] There were flaws in the drafting of the law, which was passed only with difficulty. Nonetheless, a key principle was gained that not only heralded the long process of regulating the provision of medical care but also inaugurated the specifically Anglo-American system of ‘arms-length’ control. Under this regime, the ‘watchman’ state utilises the expertise of a professional body to undertake the task, on behalf of the wider society.[84] It was an outcome that was not pre-planned but responded to the balance of expectations between Parliament, the wider public, and the medical rank-and-file, while the elite leadership within the profession played no role. Hence, rather than a Foucauldian model of an ubiquitous cultural power, enshrined within a prevailing discourse, the picture is much more pluralist and much less static. The medical professions wielded influence over their patients, but the practitioners were also themselves regulated. It was and remains an intensely socialised process, based upon negotiation and trust. Such an outcome was only possible after a long pre-history of micro-change in the reputation and practices of the eighteenth-century medicine.

1815 was an epochal moment in the Anglo-American history of arms-length professional regulation, as the Society of Apothecaries was the first professional body to be given legislative endorsement. It was a portent of much that was to follow.[85] And it was also a reminder that the gaining of social trust was and is not a one-off event but a recurrent

process, to this day remade and renewed in each generation.

IV: On the Medical Front-line

Apothecaries and surgeon-apothecaries in the eighteenth century worked on the front-line of health care, as they broadened their roles from drug-makers/dispensers to 'general practitioners' who diagnosed and treated the sick. They had patients at all social levels. Not only did successive monarchs appoint a royal Apothecary; but, by the early nineteenth century, it was common for local parish authorities across the country to retain the services of a surgeon-apothecary on a contract basis, to provide services, such as inoculation, for the poor.[86] As their numbers multiplied and their geographical spread broadened, the medical practitioners were in effect taking over the clergymen's traditional role as most ubiquitous professional 'carers' at the local level, delivering services to individuals, families, community organisations, and the specialist hospitals.

Thoughtful observers in the eighteenth century were not complacent. The medical author of the 1804 *Concise Treatise of the Progress of Medicine* noted some improvements but conceded that: 'The healing art, for a long and disgraceful period, so far from being progressive towards perfection, seemed retrograde.'[87] Every age should be critical about both the past and present state of knowledge, agreed a surgeon in 1801, when evaluating his own branch of medicine.[88] Nonetheless,, by sharing and debating their experiences, eighteenth-century practitioners were creating the infrastructure for generating and communicating a continuing culture of experimentation in the hope of improvement. Such shared knowledge encouraged their professional confidence, and spilled into public consciousness. Old superstitions were indeed being eroded, argued another medical man, who also reviewed the

state of medicine in 1801.[89] The processes of firstly inoculation and then vaccination against smallpox were beacons of hope. And sharp-eyed commentators were dreaming of new and as yet unimagined discoveries. 'From the memorable alliance between Medicine and Chemistry … the world may expect the most important consequences', a treatise on the *Progress of Medicine* announced, presciently enough, in 1804.[90]

So, while the early eighteenth century was jokingly but justly dubbed after the fastest growing profession at that time as the 'age of the lawyers', by the end of the century a new phalanx was heading the professional advance, not as part of an inexorable tide named 'progress' but through specific and often highly local deeds and even misdeeds. Such trends are formed from many contingencies, which eventually gain a collective momentum. Thus after 1815 the untrained quacks were excluded in favour of a trained corps of medical men. Old poison peddlers were becoming new civic worthies, who were launching, with state support, a new 'age of the doctors'.

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ENDNOTES

[1] Campbell 1747, p. 64.

[2] Corfield 1995, pp. 18-20.

[3] Porter in Bynum and Porter (eds) 1987, pp. 56-78.

[4] Campbell 1747, p. 64. For the professional presentation of the reputable apothecary's shop in sixteenth- and seventeenth-century London, see Wallis 2008a.

[5] Wootton 2006, pp. 184, 224-41.

[6] See esp. Porter 1989.

[7] Digby 1994; Loudon 1986; Burnby 1983.

[8] Pelling 2002.

[9] For medical publications and their readers, see Fissell 2007.

[10] Corfield 2007, pp. 57-79.

[11] Mortimer, 2005; Porter and Porter 1989.

[12] For context, see Holmes 1982; Prest 1987; Corfield 1995, pp. 18-25.

[13] Brown 1697, pp. 11, 18.

[14] Cook 1994, passim esp. pp. 25, 29.

[15] Cook 1990; Cook 1994, pp. 25-9.

[16] Anon. 1704, p. 20.

[17] de Coetlogon, 1739.

[18] Anon. 1747, p. 2.

[19] Walters 1997, p. 52. On medical incomes, see esp. Digby 1994, *passim*, and Loudon 1986, pp. 100-14.

[20] Good 1795, pp. 226-7.

[21] Lane and Tarver 1993, pp. 191-3.

[22] Ibid., pp. 189-91.

[23] Smith 1970, vol.1, p. 100.

[24] For the Edinburgh press, see Dingwall 2000.

[25] Spilsbury 1777, p. 134.

[26] Holloway in Porter and Teich (eds) 1995, pp. 77-96; Matthews 1962, pp. 208-61.

[27] See Loudon 1986, pp. 52-65 (physic), 74-80 (surgery).

[28] See Weatherhead (1841); and, for medical treatments and the abandonment of the mercury cure in the early twentieth century, Siena 2004 and Hall 2001, pp. 120-36.

[29] Porter 1992.

[30] For a standard eighteenth-century medical guide, see James, 1764.

[31] Digby 1994, pp. 90-103.

[32] Grier 1937, pp. 94-7 (cinchona), 90-2 (opiates). The importation of drugs is only now getting the research attention that it deserves: see Wallis 2008b.

[33] [Chambers] 1818, p. 18. This antedates the *Oxford English Dictionary*, which offers 1860 for first usage of GP under 'Practitioner' but proposes 1885 under 'General'.

[34] [Bailey (ed.),] 1787.

[35] *Medical Register* 1780, preface, p. vii.

[36] Pelling 2005, pp. 90-1.

[37] Pelling 2005, p. 97.

[38] Ackroyd and others, 2006.

[39] Duncan 1931, pp. 3-6, 367-8.

[40] Pelling 2005, pp. 94-8.

[41] Dandridge 1728, p. 3.

[42] Johnson 1820, p. 9.

[43] Anon. 1726: titlepage.

[44] *Medical Register* 1780, p. 118.

[45] Anon. 1739, p. 23.

[46] Jones 1844, p. 5.

[47] Brereton 1777, p. 10.

[48] Callan 2005, pp. 68-9.

[49] Walker 1799, pp. [v], 249.

[50] Alcock 1823, p. 134.

[51] Johnson 1820, p. 15.

[52] Wilson 1995; Donnison 1977; Loudon 1986, pp. 85-99.

[53] Wallis 2007.

[54] Maehle 1999, pp. 311-15; Burnby 1983, pp. 40-7, 62-78.

[55] Walters 1997, pp. 104-5.

[56] Hunting 1998, pp. 116-40.

[57] Eliot 1969, p. 194. For further analysis, see Pelling (2006), pp. 220-38.

[58] Lettsom 1801, vol. 3, p. 2.

[59] Ibid. Lettsom's endorsement of vaccination was the more striking in that he was a professed sceptic about inoculation.

[60] Miller 1957, pp. 241-66.

[61] See Smith 1987; and, more sweepingly, Razzell 1977. The global campaign is analysed in Hopkins 1989.

[62] Wootton 2006, pp. 66-8, 154-8, 166-7, 226 (criticisms) but 274-5 (muted praise).

[63] Fisher 1991; Beale and Beale 2005, pp. 79-98.

[64] For its regulations, see Anon. 1799.

[65] Corfield 1995, pp. 159-60; also Clark 2000, pp. 107, 114-16, 220; Hunting 2003.

[66] Fisher 1991, pp. 40, 53-4, 58.

[67] Corfield 1995, pp. 160-4; Granshaw and Porter (eds) 1989; Woodward 1974.

[68] Bennett 1935, p. 13; and *ODNB.*

[69] *ODNB* sub Thomas Denman (1733-1815).

[70] On this theme, see esp. Holmes 1982.

[71] Good 1795, pp. 146, 205, 147.

[72] Corfield 1995, p. 158. And for 1783, 1861 + 1911 mappings, Digby 1994, pp. 22-3.

[73] King 2006.

[74] [Perkins], 1750: handbill.

[75] L., P. 1752, p. 5.

[76] Burnby 1983, p. 110.

[77] Copeman 1967, p. 52.

[78] Barrett 1905, p. 130.

[79] Smith 2005.

[80] Good 1795, pp. 230-1.

[81] For the reform campaigns of John Mason Good (1764-1827), see *ODNB.*

[82] For this survey, see Corfe 1885, p. 24.

[83] For the 1815 Apothecaries Act, 55 Geo. III, cap. 194, see Copeman 1967, pp. 66-9; Hunting 1998, pp. 196-8; and Loudon 1986, pp. 104-30, 152-88.

[84] On this, see Bledstein 1978; Millerson 1964.

[85] See Perkin 1996; Becker 1964; and, presciently, Wilensky 1964.

[86] Williams 2005, pp. 159-86; Lane 1981, pp. 10-14.

[87] Williams 1804, p. 22.

[88] Hunt 1801, p. xviii.

[89] Ramsay 1801, p. 25.

[90] Williams 1804, p. 58.