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ROCKEFELLER MEDICINE MEN

MEDICINE & CAPITALISM IN AMERICA

WITH A NEW PREFACE BY THE AUTHOR
To Marianne, Delia, and Adrienne
Rockefeller Medicine Men

Medicine and Capitalism in America

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Throughout the nineteenth century the medical profession was almost constantly frustrated in its attempts to gain public confidence and raise professional incomes and status. Despite varied attempts to alter the competitive market economy for medical services, the dominant portion of the profession continued to be plagued by competition within its own ranks and from those beyond the pale of orthodoxy.

In this chapter we will see how the rise of science in the latter part of the century provided the solution that medical reformers had previously sought in vain. Physicians and biological researchers consciously applied the methods and principles of scientific research to problems of disease, though even in the 1860s their work had little support and played a very minor role within the medical profession. At about midcentury, however, leading reformers among elite medical practitioners took up “scientific medicine” as the ideology of professional reform and uplift. Medical science gradually provided practitioners with a somewhat more effective medical practice, enabling them to increase their credibility with the public and reduce economic competition within the profession. “Scientific medicine” was adopted as the unifying theory that enabled the dominant profession to develop strong political organization and to win political and financial support from wealthy people in society. Perhaps most fundamental, the association of medicine with science won support from the new technical, professional, and managerial groups associated with the growth of corporate capitalism.

American Medicine in the 1800s

In 1800, nearly all American physicians received their training as apprentices at the side of a practicing physician, assisting with simple techniques and mixing medications. In the eighteenth century, medical lectures had not been widely available in this country, so young men from the upper class went abroad for their medical education, especially to Scotland. The handful of Edinburgh-trained physicians in America developed very successful practices, with the wealthiest citydwellers for their clients and lucrative consulting practices besides. By 1800 only about a hundred American physicians had attended medical courses at Edinburgh, and only three American medical programs—at Pennsylvania, Harvard, and Dartmouth—were offering lectures to supplement the apprenticeship. The graduates of these institutions formed a medical elite, and together with the rank-and-file apprentice-trained physicians they formed the self-styled “regular” profession.

But most Americans were probably not getting their medical care from “regular” physicians. Whereas most of the populace lived in the countryside or small towns, most apprentice-trained doctors and the few medical school graduates lived in the large towns and cities. In Virginia, by 1800 the eleven largest towns had only 3 percent of the state’s population, yet 25 percent of all physicians known to have practiced in Virginia during the eighteenth century lived in those eleven towns.

Most Americans, when they were sick, consulted herbal practitioners. These empirical healers had no formal training but apprenticed mainly with other herbalists. Some of the herbalists were midwives, and others were men and women who had experimented with herbs and were known for their abilities to heal the sick. Lay healers were distributed throughout the countryside. They seldom relied on healing for their entire support and charged little for their services. Regular physicians were increasingly plying their art on a full-time basis and charging...
substantially higher fees, often supported by medical societies’ publishing “fee bills” to place a floor under competing doctors’ charges.

The maldistribution of regular physicians and their higher fees were only two reasons why the regular profession was widely unpopular in the first half of the nineteenth century. Very much related to their social, economic, and geographic separation from the populace, the orthodox profession’s clinical practice was greatly feared by much of the population. Not only did medicine offer little hope for curing disease, but the heroic methods used by regular doctors were unpleasant and often lethal. The lancet was the physician’s indispensable tool for nearly every ailment. Benjamin Rush, the most prominent physician in America from the Revolution through Jefferson’s time, urged bleeding for yellow fever “not only in cases where the pulse was full and quick, but where it was slow and tense.” When bleeding was not recommended, and even when it was, calomel (chloride of mercury), jalap, or another purgative was administered. The violent vomiting and purging that resulted were more detested than even the pus-filled blisters induced as another form of therapy. After attacking the body as well as the disease with bleeding, blistering, and purging, the physician administered an arsenic tonic to restore the weakened patient’s vigor.

Against this distasteful and frequently disastrous treatment by regular physicians, the empirical herbalists’ mild treatments were pleasant and at the very least did not interfere with natural rates of recovery. Their mild emetics and stimulants seemed closer to nature than the regulars’ profuse blood-letting and harsh purges.

Still experiencing competition from the empirically grounded herbalists, regular physicians resorted to ever larger doses of their therapies through the first half of the nineteenth century. Believing that any desired change in a patient’s gross symptoms was to the good and seeking to distinguish their art from lay practice, regular doctors bled their patients more profusely and doubled and tripled their doses of calomel and jalap. The profession’s heroic therapy became the focus of increasingly bitter and widespread attacks. Thomas Jefferson called them an “inexperienced and presumptuous band of medical tyros let loose upon the world.” By the middle of the century cholera victims were given an even chance of being done in by the disease or by the doctor. The profession’s fearsome and futile methods reduced public confidence in regular doctors to an all-time low.

Leading local and regional members of the profession tried many methods of increasing public confidence in doctors and reducing competition. At various times during the nineteenth century, they sought licensing laws, formed new medical sects, started medical schools and issued diplomas, organized state and national medical societies, demanded medical school reforms, and adopted codes of ethics, all with little or no improvement in technical effectiveness, credibility with the public, or their own status and fortunes.

LICENSING

Despite the antipathy of much of the populace, regular doctors at the end of the eighteenth century persuaded fellow gentlemen in the state legislatures to pass medical licensing laws to restrict or prohibit practice by herbal healers. Licensure bestowed exclusively on regular physicians the right to sue for fees. The legally sanctioned economic privilege did not provide the regular profession with an economic monopoly, but it did set them apart from and above lay healers and most other Americans.

In addition to the public’s lack of confidence in regular physicians’ clinical methods, populists in the Jacksonian era articulated their opposition to any form of class privilege. By 1850 medical licensing laws were repealed in nearly every state through the efforts of the Popular Health Movement, a loose populist movement of lay healers, herbal practitioners, artisans, farmers, and working people who fought to remove the legal sanctions that protected the privileged position of physicians.

MEDICAL SECTS AND MEDICAL SCHOOLS

The humiliated profession was badly divided. Many physicians, critical of heroic medicine, were attracted to the pleasanter new professional sects, such as homeopathy and eclecticism, that were growing in popularity. These sects built their materia medica around herbal drugs or some distinctive technology or procedure, each adding elements that enabled them to claim the necessity of extended study in their field.
Homeopathy, as formulated by its founder Samuel Hahnemann (a German physician), was based on the widely accepted medical view that the symptoms of a disease constitute the disease itself and, a corollary, that eliminating the symptoms constitutes a cure. Hahnemann found that some drugs produced the same symptoms in a healthy person (that is, caused the "illness") that they eliminated in a sick person (whom they "cured"). For example, he found that cinchona bark, at the time used to relieve the symptoms of malaria, produced malarial symptoms in a healthy person. From these observations he developed what he called the law of *similia similibus curantur*—or "like cures like." Hahnemann also maintained that diluting the dosage of a drug down to one ten-thousandth or one-millionth of its original strength *increased* the drug's potency.  

Competition between the sects and the lack of decisive public support for any one of these, left none of the sects in a position to establish control through licensing. The orthodox profession and the other sects turned to medical education and degrees as a method of recruiting and certifying new physicians in their ranks and uplifting the profession. Medical schools proliferated throughout the country, and some 400 were founded between 1800 and 1900. Local physicians organized schools to supplement their practices with lecture fees paid by medical students and, through their graduates, to fatten their incomes with increased consultations. At a time when physicians considered $1,000 to $2,000 a year a good income, the average part-time medical school faculty member earned more than $5,000 annually from student fees and private practice while more enterprising and popular colleagues earned at least $10,000. Like hundreds of general colleges started before the Civil War by rival Protestant sects and political groups, many medical schools were started by rival medical sects to improve their competitive position vis-à-vis other sects. The orthodox profession controlled by far the largest number of schools.

The proliferation of medical schools in the 1800s assured the dominance of diploma-carrying regular doctors over lay healers and physicians of other sects. By 1860 regular physicians outnumbered other sectarian doctors ten to one. The inexpensive and widely dispersed medical colleges encouraged large numbers of young men and some women to attempt careers in medicine. Graduates, many of them from yeoman farming and working-class families, filled the cities, towns, and countryside of America. Elite* regular physicians resented the competition within the dominant sect, but they saved their most venomous denunciations for competing sects. The sectarian doctor was "the greatest foe to the medical profession," argued the dean of the Tulane University medical department, because he was "an obstacle to the financial success of the respectable medical practitioner."

As the number of physicians increased, organized doctors became increasingly worried. It was clear to all physicians that producing a lot of doctors would lower rather than raise the status and incomes of the profession as a whole. Lacking the public support necessary for effective medical licensing laws and still smarting from the humiliating defeat of medical licensing earlier in the century, the reformers turned to medical school reform. Raising medical school standards and thereby reducing their enrollment, medical reformers believed, would simultaneously win public confidence in medical practice and reduce the output of doctors. The problem they faced was how to control the independent, proprietary medical schools.

**MEDICAL SOCIETIES**

Local and state medical societies, representing the practitioners, fought with medical schools in their areas. In 1847 the societies banded together to form the American Medical Association (AMA). At the founding convention, leading practitioners passed resolutions that sought to raise requirements for preliminary education prior to admission to medical school. So few Americans had the requisite education at the time that enforcement of these standards, according to historian William Rothstein, "would have closed down practically every medical school in the country, and would have depleted the ranks of formally educated physicians in a few years."

From its founding onward, the AMA was hostile to the interests of proprietary medical colleges and their faculties. The practitioners wanted to reduce the output of medical schools in

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*The term "elite" refers somewhat loosely to physicians who, by their reputations for clinical or research techniques, by income, and/or by organizational leadership positions, had achieved prominence within the profession.
order to reduce competition within the profession, while the medical faculties opposed any attempted reforms because of their interests in maximizing their lecture fees and future consulting fees. Unfortunately for the practitioners, the reform leadership mistakenly thought that including medical schools in the new national organization would allow the medical societies to control them. This strategic mistake immobilized the AMA as the vanguard of practitioners' interests until 1874 when medical college voting rights in the association were abolished.

CODES OF ETHICS

The AMA's attacks on medical education and especially on other medical sects were supported by a "code of ethics" adopted at their first convention. With the code the AMA hoped to deny the ability of patients to judge their physicians or disagreements between physicians, to encourage attacks on "irregular" doctors and "quacks," and generally to reduce competition among regular physicians. At the same time that the AMA complained about the low standards of medical education, the association commanded patients to trust their doctors. "The obedience of a patient to the prescriptions of his doctor should be prompt and implicit," the code of ethics instructed. The patient "should never permit his own crude opinions as to their fitness to influence his attention to them."13

These efforts to bolster the profession's falling economic status and power were legitimized on moral and ethical grounds by the medical societies. Since the colonial period, violation of "ethical codes" had been grounds for ostracizing nonconforming physicians. Codes were used not only against other sects and lay healers but against members of the regular profession who consulted with homeopaths and eclectics and even against the developing medical specialties which offered competition to the general practitioners. The AMA code failed to win public support or stamp out competition although the medical societies' attacks on members for code violations intimidated some doctors and increased intraprofessional antagonisms.16

In short, conflicts between practitioners and medical faculties, generalists and specialists, and "regular" physicians and other sects kept the profession badly divided throughout the nineteenth century. The incoherent strategy of the regular profession's leadership and the weak structure of their organization, the AMA, left the field with no sect able to secure undisputed control over the competitive marketplace.

Medical school output continued unabated. By the end of the nineteenth century, the United States averaged one physician to every 568 people.17 Compared with prevailing ratios in European countries (Germany, with one doctor to 2,000 population, was the favorite example), the United States was "overcrowded" with physicians. Physicians' incomes ran the gamut from poor ($200 a year) to wealthy (as much as $30,000 a year for a small number of elite doctors). The chief complaints of the most prominent professional spokesmen by the end of the century were the "surplus" of doctors, "low" incomes, and the low social status of the profession.

Three underlying problems plagued medical reformers who tried to heal these wounds. First, physicians lacked an agreed upon technical basis for settling among themselves disputes between the sects. Without public consensus on technical criteria of effectiveness and validity, all sects competed for business in the medical market. But without sufficient public confidence in the validity of any one sect, no sect could win a monopoly of medical practice and thereby eliminate the competition.

Second, their lack of a technical basis for establishing public support put them all in a weak position to establish political control over entry into medical practice. Earlier efforts to use licensing ended in humiliating defeat for the regular profession because of organized opposition from other sects and a distrustful public.

Third, within at least the dominant sect different economic interests divided those who practiced medicine from those who trained future practitioners. Practitioners wanted to restrict the supply of physicians, and part-time faculty wanted to preserve institutions that were lucrative additions to their own practices.

INCOMPLETE PROFESSIONALIZATION

Without actually having public confidence in their technical ability, physicians throughout the nineteenth century and earlier had nevertheless proclaimed norms to support their authority over the lay public. Demands for recognition of the regular profession's technical competence (in which they undoubtedly
believed) were the means of legitimating their claims to professional authority. The recognition of that authority, however, was seen as necessary to the profession's controlling the economic conditions of its work. By proclaiming a set of norms and values associated with their work, regular physicians hoped to end the competitive market for medical services and to win a regulated market for themselves.

The basis of professional status and power is still debated by sociologists, who traditionally have posed a set of essential features that are supposed to distinguish professions from the general run of occupations. In 1928, A. M. Carr-Saunders, the father of the sociology of professions, defined a profession as an occupation: (1) based on specialized intellectual training or study, (2) providing a skilled service to others, and (3) in return for a fee or salary. Thirty years later, William Goode stressed prolonged specialized training in a body of abstract knowledge and a collectivity or service orientation as the "core characteristics" of professions. The list of formal characteristics of professions has been extended by other sociologists to include a systematic body of theory, acceptance of the authority of the professional by all who come to him or her as clients, protection of the professional's authority by the political community, a code of ethics to regulate professional relations, and a set of values, norms and symbols that build solidarity among the profession's members.

However, lists of formal characteristics turn out to be fairly useless in the real world in distinguishing professions from other occupations. Even worse, they tend to gloss over the political and economic dynamics that are essential to the process of professionalization, making professional status and power appear an inevitable and desirable feature of modern societies. In reality, as Eliot Freidson has observed, any occupation wishing professional status creates a systematic body of theory, claims exclusive authority of its practitioners, adopts a code of ethics, tries to build solidarity among its practitioners around formal values, norms, and symbols, and otherwise cloaks itself with the well-known medallions of professions to support its claims. "If there is no systematic body of theory," Freidson argues, "it is created for the purpose of being able to say there is."

The commitment to service, argues Harold Wilensky, is "the pivot around which the moral claim to professional status revolves." Like many such professional norms, there remains no clear evidence that a service orientation is in fact strong and widespread among professionals. In reviewing the sociological literature that makes such claims, Freidson has concluded: "the blunt fact is that discussions of professions assume or assert by definition and without supporting empirical evidence that 'service orientation' is especially common among professionals."

Indeed, many academic social scientists have been beguiled by their own (usually self-serving) beliefs in "science" and "expertise" into confusing professional norms with the reality of professional practice and motivation. Codes of ethics were accepted by some sociologists as genuine efforts by the profession to guarantee competence and honor. Carr-Saunders believed that "if the foundations of the codes were better understood, they would not be generally regarded with hostility."

More recently, some sociologists have approached professional norms more critically. Everett Hughes, for example, argues that the widespread acceptance of norms, like the professional "should have almost complete control over what he does for the client" and "only the professional can say when his colleague makes a mistake," have been used by professionals to hide mistakes.

What much of the sociological literature ignores in examining the process of professionalization is how essential political power is in gaining and maintaining professional status. As the history of the medical profession in the nineteenth century demonstrates, without sufficient political power the profession remained unable to control its economic and working conditions. Initial efforts at licensure were defeated by a popular movement of lay healers and other Jacksonian-era populists. Attempts to use medical education as a strategy of reform were thwarted by the organized profession's lack of control over medical schools. The leading reformers organized a national professional association, but the medical school faculties were beyond the reach of the American Medical Association. Ethical codes, articulating prevailing professional norms, failed to win public support for the profession and could not overcome intraprofessional competition. What the medical reformers sought was the power to enforce the instruments of professionalism that assure high incomes, social status, and continued prosperity for the profession.