

# The Social Construction and Organisation of Medical Marginality: the Case of Homoeopathy in Mid-Nineteenth-Century Britain

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THE THEME OF THIS BOOK was first articulated to potential contributors as 'approaches and concepts' or, more generally, by posing the question: 'how can the subject of unconventional medicine be studied in an historical perspective?'

A variety of responses to this problem – as this book makes clear – are, of course, possible. Most, however, probably fall into either of two broad (but not unrelated) categories: one emphasising methodological issues – the techniques of gathering data – and the other, theoretical or conceptual concerns, or what in more general terms might be called the problems of determining *what* data is important or relevant to begin with, and of its *meaning*.

The argument in this paper falls into the second of these broad categories. It begins, then, with the proposal that 'the subject of unconventional medicine' can only be studied in an historical perspective, if 'conventionality' or 'orthodoxy' is seen as a 'social construct', as the outcome of social and political processes, or of the mobilisation of power by particular (usually occupational) groups in a way which allows the successful marginalisation of rival knowledge claims, practices and practitioners.

This, in fact, is a fairly conventional claim in the sociology (or social construction) of knowledge. Few practising sociologists, especially in this era

of postmodern scepticism about claims to knowledge in general, would probably find much trouble in agreeing with it. But the consequences for a programme of research into subjects like the history of unconventional medicine are quite radical. To begin with, it immediately follows that the social and political divisions between 'orthodox' and 'unorthodox' groups of practitioners cannot be explained as the product of a process of epistemological discrimination which separates 'truth' from 'falsity' or of what is 'effective' from the 'innocuous' or 'dangerous'.

Indeed, to put the argument in its boldest form, there is nothing in any particular therapeutic theory, approach or technique *itself* that determines its status as orthodox or otherwise. What does matter in this regard is the ability of a particular set of social actors to render their account of reality credible and legitimate. Alison Winter's revealing study of the introduction of inhalation anaesthesia in the 1840s is a good illustration of this phenomenon.<sup>1</sup> Here mesmerists, despite some promising beginnings, were quickly marginalised by the ensuing 'etheral epidemic', not because their work was really any less convincing in terms of pain relief compared to the results achieved in early demonstrations of etherisation, but because the latter, by leaving the surgeon more fully in control of the theatre and his patient, was more congenial to the occupational interests of surgeons in general.

Similarly, Fox suggests that Listerism was not the antiseptic triumph of conventional history, but an approach introduced in *opposition* to a rival and co-existing set of principles – those of asepsis.<sup>2</sup> For many practitioners, asepsis was the approach of choice based not (primarily) on evidential grounds, but because Listerism seemed to recast the surgeon as a potential and dangerous pollutant in a Victorian society which prized physical and moral cleanliness. Indeed, the aseptic environment of the modern surgical theatre, usually credited as the natural product of ideas first pioneered by Lister, can actually be traced to a rival therapeutic tradition which also, and rather importantly, had more congenial implications for the status of medical men than Listerism.

A third example, which brings me closer to the substantive material comprising the bulk of the remaining discussion, concerns the development of homoeopathic theory and practice in the last century. By the 1870s, homoeopathic principles regarding the size and frequency of dose and the indications on which particular remedies should be prescribed, together with research designed to expand the pharmacopoeia, all began to manifest themselves in regular theory and practice.<sup>3</sup> Leading homoeopaths of the time were quick to draw attention in both print and speech to the existence of

this therapeutic traffic. Leading allopaths (such as Sydney Ringer, Professor of Therapeutics at University College, London; Charles D.F. Phillips, Lecturer in Materia Medica and Therapeutics at the Westminster Hospital Medical School; Lauder Brunton, Physician to the St Bartholomew's Hospital; and John Harley, Fellow of the Royal College of Physicians) were among the more prominent of regular medical men who were taken to task by homoeopaths for writing, teaching and practice which reflected a closet acquaintance with homoeopathic literature.

While homoeopaths welcomed the fact that they had been able to 'leaven the loaf' of allopathic medicine, they were, however, furious that regular practitioners (with one or two honourable exceptions) were coy about acknowledging the sources of their new therapeutic recommendations. As John Drysdale, a prominent Liverpool homoeopath, observed at the British Homoeopathic Congress (28 September 1870) in Birmingham:

... no expensive medical work could at present be published if it contained anything favourable to homoeopathy: accordingly the subject is entirely ignored, or, if alluded to must be mentioned with reprobation. These books abound in plagiarisms from our school, and its influence may be seen in every page almost, yet the subject must not be named. The private and hospital practice of a physician may display in almost every prescription the fruits of knowledge gathered by our school, and yet he does not honourably acknowledge their source ...<sup>4</sup>

This 'acknowledgement' could not be given for the simple reason that, at the beginning of the 1850s, regular doctors had already decided that homoeopaths were no longer colleagues worthy of professional recognition. They had been ostracised from normal professional life and so, while their therapeutic initiatives could be grafted on to regular practice, any real recognition of the origins of this new growth could not be forthcoming.

The point of this third example is, hopefully, clear enough. There was nothing in the practice of minute doses, their frequency, or the indications on which they were prescribed which, in themselves, signalled medical heresy at the time. It all depended on who was using them, and on which group of practitioners had the power to draw the boundaries of orthodoxy. Homoeopaths – who never numbered more than a few hundred doctors in Britain – were labelled as either 'fools' or 'knaves' for advocating a particular therapeutic approach. In the hands of regular medical men, on the other hand, these same techniques were simply seen as following the latest advice of their own leading authorities.

These examples are meant to illustrate what I would argue is an

important consideration in beginning a study of unconventional medicine in historical perspective. Instead of seeing the social structure or organisation of 'fringe' or 'marginal' or 'irregular' practice as the result of any epistemological break with 'conventional' knowledge, it is rather the case that therapeutic deviance is a product of the social organisation of an (occupationally) active orthodoxy. Irregular practice, then, in this perspective, is less a product of simple theoretical difference than the outcome of political struggle and the mobilisation of occupational power by certain groups of doctors. It further follows, as Roy Porter's work on the eighteenth-century medical market shows, that it makes little sense to talk about any clear division between 'irregular' and 'regular' practice during a period when medical men in general lacked organisation and the ability to exercise the occupational control associated with professionalisation.<sup>5</sup>

Using this perspective to understand the development of homoeopathy in Britain in the nineteenth century – which I want specifically to address here – it becomes apparent that the conventional wisdom, whereby strategic theoretical differences led to the founding of exclusive occupational organisations by homoeopaths (an exclusivity that invited a subsequent policy of ostracism by erstwhile regular colleagues), needs to be re-examined. Instead, what seems to have happened is that the strategy of exclusion adopted by the emerging profession stimulated and strengthened the formation of homoeopathic organisations which, once developed, institutionalised the very epistemological differences of which the regular school complained. In short, the social and political organisations developed by homoeopaths were not the reason for their exclusion from normal professional relations, but rather their response to it. Therapeutic difference was thus the end product of a political struggle rather than its cause.

It is true that the foundation of the British Homoeopathic Society (BHS) by the doctors Frederic Foster Quin, Samuel Partridge, Victor Massol and Mr Hugh Cameron on 10 April 1844 predated by some seven years the development of strategies by the Provincial Medical and Surgical Association (PMSA) which were intended to ostracise homoeopathic doctors from contact with their regular colleagues (the PMSA became the British Medical Association in 1856). But a number of points need to be noted about this period. First, in the 1840s, it is clear that Quin, under whose initiative the BHS had been formed, was a jealous guardian of the professional integrity of homoeopathy and the doctors who practised it. He was quick to take firm action to distance the society from any connection with lay populists, like the Rev. Thomas Everest, who had tended to 'preach homoeopathy from the pulpit', and the wealthy silk merchant William Leaf,

who had helped to arrange exhibitions of thankful patients 'dramatically cured' by homoeopathic treatment.

An editorial in the *British Journal of Homoeopathy* (the official voice of the BHS) in 1846 is revealing in this regard. The previous year had seen the formation of the English Homoeopathic Association (EHA), a mixed body of medical and lay enthusiasts, whose aim was to promote and publicise homoeopathy, and to found and fund hospitals (like that in Hanover Square, and later, in 1850, the Hahnemann Hospital in Bloomsbury, at which both Leaf and Everest happened to hold positions as vice-presidents). The editorial address – the voice is almost certainly that of Quin himself – observed of these developments that 'the experience of other countries has taught us that the only way to secure the progress of homoeopathy is by rigid exclusiveness in all matters connected with its scientific development ...'.<sup>6</sup>

This 'exclusiveness' was clearly being threatened by the EHA and, by 1847, things had deteriorated still further. Stung by the activities of doctors like Paul Curie, one of the medical officers at the Hahnemann Hospital, and supporters like Leaf, who Quin argued '... had done so much to compromise Homoeopathy, and to reflect discredit, in the estimation of the profession and the public, upon Homoeopathic practitioners in England ...',<sup>7</sup> he insisted that any future connection between the BHS and lay supporters would have to be one in which the latter confined themselves to fund raising activities only. Quin's arguments and his reputation were sufficiently convincing to cause a split in the EHA: some members left to form the (still existing) British Homoeopathic Association (BHA). This conducted itself on principles much more in accord with those insisted upon by Quin and, having helped to raise sufficient funds to realise his ambition of founding the London Homoeopathic Hospital, which opened on 10 April 1850, the BHA disbanded (until 1902) on 22 August 1849.

Clearly, Quin's early efforts to establish an institutional framework for those doctors interested in homoeopathy was not designed to antagonise 'regular' colleagues. On the contrary, his scrupulous concern for the reputation of homoeopathy in general and the BHS in particular demonstrates a commitment to gain and sustain the respect and recognition of the bulk of the profession. Quin's ambition was to win friends, not to make enemies – a disposition which characterised his personal relations with orthodox colleagues as much as it did his work for the BHS.

Secondly, it is also clear that most homoeopaths in the 1840s were not radicals in terms of their therapeutic allegiances. Instead, eclectic practice was preferred. It is not easy to find examples of British homoeopaths during this period who were prepared to observe, or declare, that

homoeopathy was, as it were, 'the whole truth, and nothing but the truth'. Instead, the prevailing orientation was more akin to that favoured by William Henderson, Professor of Medicine and General Pathology at the University of Edinburgh, who argued that:

If any are still so prejudiced against the ordinary practice, as to deny its possession of many palliative, and not a few, curative expedients, which render it, with all its imperfections, of eminent service to mankind, when administered with discrimination and ability, I must avow my hearty dissent from their opinion.<sup>8</sup>

This willingness to see merit in both homoeopathic and allopathic approaches was also, in these early years, reciprocated in some regular literature. Even editorial comment in *The Lancet* was moved to acknowledge that:

A world of mischief has been produced before now by long protracted doses of powerful medicines in chronic cases, many of which would, on the contrary, have been benefited by non-interference with medicine, or – which comes to the same thing – by homoeopathic treatment.<sup>9</sup>

Such sentiments may not have been that frequent, but they were by no means uncommon. Sir John Forbes was prepared to endorse them still further. In an extended reply to Henderson's *An Inquiry in to the Homoeopathic Practice of Medicine*,<sup>10</sup> Forbes drew the uncomfortable conclusion that:

If it is nature that cures in homoeopathy, and if homoeopathy (as we have admitted) does thus cure, in certain cases, as well as allopathy, do we not by this admission, inevitably expose ourselves defenceless to the shock of the tremendous inference – that the treatment of many diseases on the ordinary plan must, at the very best, be useless; while it inflicts on our own patients some serious evils that homoeopathy is free from, such as the swallowing of disagreeable and expensive drugs ...?<sup>11</sup>

Forbes was soon to pay dearly for sentiments which came to be interpreted as too sympathetic to homoeopathy. But, at the time, they were symptomatic of a willingness by practitioners of whatever therapeutic persuasion to concede that both homoeopathy and allopathy had something of value to contribute to doctoring. Homoeopathy had still to be constructed as a threat to all rational thought; and homoeopaths had not yet been fully stigmatised as 'fools or knaves' who were not worthy of professional respect or recognition. By now, however, this fate was imminent.

The third point to make about the period *prior* to the progressive

implementation of the policy of professional ostracism of homoeopaths, which began in 1851, is that the majority of such doctors had not felt it necessary to join organisations like the BHS. Atkin's Homoeopathic Medical Directory gives details of the 177 doctors practising in England, Scotland, Ireland and the Channel Islands by the end of 1852 (there were none in Wales). Of these, only 42 (24 per cent) had felt it important to join the BHS.<sup>12</sup>

Two decades later, however, by the end of 1873, the number of doctors listed in the Homoeopathic Directory had risen to 279. (There were still none in Wales, and this total also excludes six doctors whose overseas qualifications did not entitle them to registration under the Medical Act of 1858.) By then, 149 (53 per cent) of these belonged to the BHS. Furthermore, most of this increase in membership had come in the 1850s and 1860s: 106 doctors had decided to join the ranks of the society during this period. Of the remaining 130 doctors (i.e. those practising homoeopaths listed in the directory for 1873 whose names do not feature on the BHS membership list), most are shown as having developed alternative solidarities among the new provincial homoeopathic associations and societies.<sup>13</sup>

As indicated, the PMSA's campaign to ostracise homoeopaths had begun in 1851. Its August meeting of that year had appointed a committee to consider what action might be taken. The resulting resolutions were that homoeopathy was absurd; that no reputable medical practitioner should consort with it; that homoeopaths were guilty of heaping abuse on the regular profession (a partial truth at best – Thomas Wakley, editor of the reform minded *Lancet*, heaped far more abuse on the heads of leading medical figures than was ever done by Quin's colleagues); that no member of the PMSA should entertain professional contact with homoeopaths; and that homoeopaths, together with any regular doctors who consulted with them, should cease to be members of the association.<sup>14</sup> These resolutions were endorsed, in some cases strengthened, and adopted at the PMSA's meeting in Oxford the following year. Moves were made to incorporate the resulting bylaws into the established legal framework of the BMA in 1858. In 1861, the BMA reaffirmed its general support for all these policies.

The effect of this political campaign, however, was rather the reverse of its apparent intention. It served to construct and sharpen a professional and therapeutic divide which many of those affected had not previously contemplated. Quin's whole enterprise for homoeopathy had been designed to win acceptance, respect and recognition for this form of treatment and the doctors who employed it. Most homoeopaths were of an eclectic persuasion, using a variety of approaches, and only a minority felt the need to

wrap themselves in the protective clothing of a specialised professional association. But the PMSA's actions changed all this: the policy of exclusion and ostracism forged a homoeopathic identity which was largely foreign to many earlier exponents. In short, before the 1850s, there were merely doctors who practised homoeopathy; afterwards, there were homoeopaths who, as far as the regular profession was concerned, could no longer claim to be doctors. The result was a strengthening of the institutional apparatus of homoeopathy and a hardening of professional and therapeutic distinctions.

What, then, motivated the rank and file of regular practitioners, represented by the PMSA, to launch the campaign against homoeopathy? Much of the answer is bound up with the long movement for medical reform in Britain which began in the first half of the nineteenth century.<sup>15</sup>

This period saw the accelerating demise of the traditional distinctions between physician, surgeon and apothecary, and the emergence of the general practitioner with licences from more than one college. In part, this was a response to the rapid reconfiguration of demand for medical services which accompanied urbanisation and industrialisation. In part, too, it was a response to the fact that medical practice was a highly competitive affair. There were too many doctors, and most barely managed to maintain the outward appearance of a gentlemanly lifestyle without which more affluent patients could not be attracted. The ordinary general practitioner suffered, too, from the fact that medicine was not generally regarded as a 'profession' which merited the same public regard as the law, the church or the army. Moreover, the average doctor was also besieged by competition from untrained, unlicensed healers and sellers of nostrums and cure-alls.

The only groups of practitioners who were unaffected by these problems were the elites of the royal colleges in London (the Royal College of Physicians, the Royal College of Surgeons and the Society of Apothecaries). The colleges also represented, in effect, the governing bodies of the profession. These facts combined help to explain the frustrations of most medical men: they had no say in the running of their profession, and the fellows of the colleges had little interest in reform. It was thus with the support of campaigning editors like Thomas Wakley of *The Lancet* that movements like the PMSA were born. The ordinary general practitioner was looking for a vehicle through which he could argue for a more democratic voice in the running of the profession, and through which claims for the reform of education and, eventually, of the remuneration and status of medical men could be pressed.

Opposition to reform from the colleges meant that the campaign was



a long one and that many of the proposals presented to parliament failed. Eventually, however, a compromise of sorts was reached, and the Medical Act of 1858 was approved. Among its variety of provisions was the establishment of the Medical Register. This register did not make unqualified practice illegal, but it did establish a national register of practitioners possessing qualifications recognised by the new governing body of the profession – the General Medical Council – and so enabled the public to distinguish between bona fide doctors and other kinds of healers.

Homoeopathic doctors who had qualified in Britain, of course, all possessed accreditation which allowed them a perfectly legitimate place on the Medical Register. This was a disappointment to the advocates of reform. Homoeopathy's friends in parliament, notably Lord Grosvenor, had managed to stave off attempts to extinguish the therapy by legislative fiat. But the socioeconomic environment of the ordinary practitioner that underpinned the movement for medical reform also helps to explain the rising antipathy to homoeopathy which resulted in the exclusionary policies of the PMSA/BMA in the 1850s.<sup>16</sup> It was a difficult period for medical men. Doctors were anxious about incomes, social status, public reputation and the credibility of medicine as a discipline, and they were conscious of the need to distance themselves from the variety of unlicensed practitioners. And homoeopaths appeared, at the time, to strike at most of these sensitive issues.

As far as profitable practice was concerned, it was well recognised that there was money to be made from homoeopathy. Homoeopathy's fee-paying clientele (excluding the many thousands of working class poor treated on a charitable basis at hospitals and dispensaries) came to a significant extent from the wealthy, and from the new, as well as more traditional, social elites. This is indicated by several pieces of evidence.

First, the geographical distribution of doctors mirrors the developing centres of wealth and fashion associated with Victorian society. Of the 177 homoeopaths practising in Britain at the end of 1852, 66 were based in London, with other significant concentrations in burgeoning merchant and industrial centres such as Liverpool (doctors Drysdale, Hilbers, Moore, Roche and Stokes), Manchester (doctors Harrison, Dowal, Matthews, Phillips and Walker), Birmingham (doctors Fearon, Galloway, Johnson, Lawrence and Parsons), Leeds (doctors Booth, Craig, Cresswell and Irvine), Edinburgh (doctors Allshorn, Henderson, Laurie, Lyschinski, Paisley and Wielobycki) and Dublin (doctors Blyth, Luther, Scriven and Walker). Fashionable spa towns, such as Bath, Cheltenham and Leamington, also supported numbers of homoeopaths, as did the newly emerging coastal resorts – like Torquay, Weston-super-Mare, Brighton, Hastings

and Scarborough – which were increasingly patronised by the ranks of respectable society.<sup>17</sup>

Homoeopathy's links with wealth and status are, secondly, also clear from those who supported its institutions. As early as 1853, there were three homoeopathic hospitals in Britain (two in London and one in Manchester) and, including Ireland and the Channel Islands, a total of 57 dispensaries.<sup>18</sup> These, of course, were charitable foundations, whose main rationale was to provide care for the sick poor. But, as further research begins to show, the particular pattern of patronage which underpinned the work of hospitals and dispensaries gave the homoeopaths who worked in them strong links to networks of social elites whose wealth and recommendations could form the basis of flourishing private practices. The London Homoeopathic Hospital, for example, could list Her Royal Highness the Duchess of Cambridge, His Grace the Duke of Beaufort, Field Marshall the Marquis of Anglesey, His Grace the Archbishop of Dublin, the Marquis of Worcester, the Earl of Essex, Viscount Sydney, Lord Gray, Viscount Maldon, Lord Francis Gordon, Lord C. Paget MP, Lord A. Paget MP, Lord G. Paget MP, Colonel Wyndham and, notably, Quin himself among its officers and patrons.<sup>19</sup>

This pattern of support might not be unexpected in London – but the alliance of aristocratic, clerical and military patronage is one that is repeated in much humbler institutions. A further (unexceptional) case is the Wolverhampton and South Staffordshire Homoeopathic Dispensary. By the 1870s this institution had developed three branches (in Dudley, Wellington and Walsall), and could list among its patrons the Duchess of Sutherland, the Earl of Lichfield, Sir William Biddulph-Parker (baronet), the Honourable and Reverend Adelbert Anson, Sir John Morris (knight and ex-mayor), the Reverend Henry G. De Bunsen and the Reverend George Fisk.<sup>20</sup>

Homoeopathy's connections with social elites was something which first developed, of course, in its European homelands. But it was (and remains) a therapy which has had enduring appeal for people of rank. In the 1930s, for example, the BHS and the BHA were still being talked about as nothing more than 'rich men's talking shops', mainly by those who were irritated at the perceived complacency of these organisations in the face of decline.<sup>21</sup> Members of the British royal family continue even today as active patrons and supporters of homoeopathy. The connection is one which is sociologically interesting and can perhaps be explained in terms of the ways in which certain 'styles of life' or patterns of consumption can be used to signal, in Max Weber's terms, status group membership. Homoeopathy was something that could easily function as a symbol of social status.<sup>22</sup> In

contrast to regular practice, it appeared to be refined, having subtle and complex rather than 'gross' effects; it appeared to act at a spiritual rather than a material level; and it certainly appeared that only the wealthy could afford to pay so much for so little. Alternative therapeutic options, like mesmerism, were, on the other hand, tarnished by stronger ties with popular culture and other disreputable activities.<sup>23</sup>

Homoeopathy, then, was clearly tapping into some lucrative medical markets. In an overcrowded profession, where most medical men were struggling to sustain a living, homoeopaths were almost certain of being able to attract customers of wealth and rank and of quickly developing a flourishing practice. As Robert Dudgeon, one of London's most eminent homoeopaths (who, in the 1870s, was practising at 53 Montagu Square) remarked:

... any practitioner who declared himself a follower of Hahnemann was sure of getting rapidly in to large practice. The mere material inducements to avow oneself a homoeopathist were of the most tempting character.<sup>24</sup>

These sentiments were echoed on the allopathic side by writers such as the editor of the *London Medical Review* who ruefully remarked that, 'I venture to say, there is scarcely a medical man in the kingdom who has not felt the influence of this "delusion" on his professional income.'<sup>25</sup>

Needless to say, in such circumstances the ordinary general practitioner was keen to find ways of capping and controlling what was clearly perceived to be a piece of unprincipled commercial opportunism by his homoeopathic rivals, and the consultation ban, and the ostracism of those who broke it, looked correspondingly appealing as ways of securing this objective.

The erosion of remunerative opportunities for regular practitioners may have been even greater than that suggested by the evidence above, for this period also saw an explosion of publications aimed at the domestic market. By the 1870s there were at least 40 titles from which the interested lay person could choose. Among the most popular available from British authors were Dr Chepmell's *Domestic Homoeopathy* (eighth edition), Dr Allshorn's *Handy Book of Domestic Homoeopathic Practice* (fourth edition), Dr John Epps's *Domestic Homoeopathy* (sixth edition), Dr Richard Epps's *Family Practice* (sixth edition), Dr Newman's *Homoeopathic Family Assistant* (third edition), Dr Pope's *Popular Guide to Homoeopathy for Families* (third edition) and Dr Ruddock's *Lady's Manual of Homoeopathic Treatment* (fifth edition). The prize for the most popular text of all, however, went to Dr Laurie; his *Homoeopathic Domestic Medicine* had run to its twenty-first edition by 1874

and his *Epitome of the Homoeopathic Domestic Medicine* to its twenty-seventh.<sup>26</sup>

These texts could be obtained from one of the big homoeopathic publishing houses, such as Henry Turner & Co., who had offices in London and Manchester, or, more commonly, from one of the many chemists specialising in the supply of homoeopathic remedies. There were 117 of these chemists throughout England, Scotland, Ireland and the Channel Islands by the middle of the 1870s.<sup>27</sup> Typically these establishments would also supply customised medicine chests which were specifically designed to accompany the most popular of the domestic treatises. One of a batch of advertisements appended to the back pages of the Atkin's 1853 *Directory* is typical of what was offered. Charles Lane, Homoeopathic Chemist, of 146 Sloane Street, Chelsea, London advertised 'The latest editions of all the Treatises on Homoeopathic Domestic Medicine ...' together with 'A large supply of Medicine Chests and Cases for Professional or Domestic Use ...' which were arranged '... to accompany any of the various treatises on Domestic Medicines.'<sup>28</sup>

The consumers of these products were almost certainly middle-class families, and the purchasers probably wives and mothers who served as the traditional health keepers of spouses and children. Given the scale of the activity involved, however, the ordinary practitioner could not have looked on these developments with any degree of approbation. Every child treated on the home front by its mother represented a lost fee, and every mother gaining confidence in the management of domestic illness seemed to suggest that a degree of professional expertise in medical matters could be developed by the amateur. In an era when the public's regard for the reputation of medical knowledge was fragile, and when efforts were being extended to hound quacks from practice and to improve the standards of medical education and training, homoeopaths' deliberate encouragement of self-diagnosis and self-treatment, even by the educated sections of the public, must have seemed like an act of deliberate betrayal of professional solidarity.

Indeed, in the difficult circumstances leading up to the Medical Act of 1858, the general impression which many medical men formed of homoeopaths tended to be that of a group of unscrupulous doctors whose main interest was in turning a quick pound, and who were cynically promoting a palpable – albeit popular – absurdity in a way which brought disrepute to the profession. Homoeopaths, after all, seemed to be pandering to fashionable affectation in a way which siphoned important fees away from regular doctors; they seemed to be more interested in exploiting and promoting commercial opportunities among Britain's social elites and the

educated middle classes than in serving the public interest; and they seemed to undermine the status of medical expertise by teaching the public to practise upon themselves. In short, they seemed to offend in quite radical ways both good sense and good manners.

Although homoeopaths were, on the whole, innocent of these charges and were certainly not quacks, it was not difficult for most doctors to perceive them as sharing sufficient characteristics with the charlatan to put them in the same camp as the imposter, the rogue and the scoundrel. This, at least, was the view of Thomas Wakley who, from the pages of *The Lancet*, thundered the case for medical reform, for the protection of the interests of the ordinary practitioner, and for the exposure and excision of quackery in all its forms:

We propose to extirpate unsparingly everything that openly or secretly lowers the dignity or rank of medical science and its professors. The IDEA of a Profession, of a Faculty, in the maintenance of which all, the highest and the lowest, are alike interested, and which the elder medical men held in such reverence, has well nigh disappeared from us. This must be restored. Every offence, every injury done to the profession thus embodied, whether by members of the profession or by interlopers, is *quackery* to our code [emphasis in the original].<sup>29</sup>

It was the strength of sentiments such as these, and the real material interests which underpinned them, which led to the campaign to exclude homoeopaths from the ranks of the recognised profession. But the result was not what was intended. Homoeopathy flourished in the 1850s and 1860s, and in the face of medical hostility homoeopaths closed ranks. The result was not the demise of homoeopathy, but the creation of a distinct homoeopathic identity and an array of institutions which nurtured and promoted it.

It is worth noting that this process was not confined to Britain. As Robert Jütte shows, the elaboration of an apparatus of distinctive homoeopathic colleges, societies, journals and hospitals in Germany and the USA constituted, in effect, a process of professionalisation.<sup>30</sup> This process, he argues, was first initiated as a specific strategy to secure the survival of homoeopathy in the face of increasing medical hostility (and was successful not least because of the links between homoeopathy's aristocratic supporters and the levers of political power which are also familiar features of the British case). The 'paradox of professionalisation' which resulted, Jütte suggests, was that just as the institutional identity of homoeopathy hardened as a product of regular hostility, the very presence of organised sectarian dissent within medicine also served to remind regulars of their own

therapeutic commonalities, and helped to forge a new sense of professional solidarity and identity during a period of heightened occupational insecurity.<sup>31</sup>

What, then, comprised the particular array of institutions in Britain which developed in response to regular hostility, and who were the doctors who worked within them? The evidence suggests that, in terms of background and education, homoeopaths were, in the 1850s, not dissimilar to the mass of general practitioners. The great majority held more than one qualification, the most frequently listed being the MD degree, the LSA (Licentiate of the Society of Apothecaries) and the L or MRCS (Licentiate or Member of the Royal College of Surgeons).<sup>32</sup> The great majority of practitioners thus possessed qualifications in both medicine and surgery, which was the usual pattern at the time, although few seem to have been Licentiates or Members of the Royal College of Physicians.

The first institution which doctors could have joined was, as described above, the British Homoeopathic Society. Formed in 1844, its objective was the advancement and extension of homoeopathy and, to this effect, meetings for the reading and discussion of papers and communications were held on the first Thursday of every month and an Annual Assembly in May or June. Quin remained its president for many years, supported by a council whose officers were elected annually. Doctors could belong as fellows or as ordinary, honorary, corresponding or inceptive members. Ordinary members had to be medical men residing in the United Kingdom and members of a recognised university, college of surgeons or licensing body whose knowledge of homoeopathy and experience of its principles and practice enabled them to treat patients using homoeopathic methods. New candidates had to be proposed by two existing members, and they were elected by ballot. Significantly, in terms of hardening a distinctive homoeopathic identity, the society's major increase in membership came, as already argued, in the 1850s and 1860s after the exclusionary tactics of the PMSA had begun to bite.

The following year (in May 1845) saw the institution of the English Homoeopathic Association.<sup>33</sup> Its president was Lord Grosvenor MP, and its committee of 22 comprised both doctors and members of the public. It was this group's activities in promoting and publicising homoeopathy which had caused some disquiet on the part of Quin. This was probably the first of the internal divisions within homoeopathy itself in Britain. Quin allied the London Homoeopathic Hospital to the BHS and the short-lived BHA, preferring to keep the EHA and the hospitals with which it was associated (first in Hanover Square, and then in Bloomsbury) at arm's length.

Four years after the formation of the BHS, on 10 April 1848, the Hahnemann Publishing Society was instituted. Its rationale was to promote the publication and circulation of practical works on homoeopathy, a new materia medica and a pharmacopoeia. By 1853 it had 28 members, drawn from across England and Ireland, with a committee composed of the doctors Black, Drysdale, Dudgeon, Ker and Madden.<sup>34</sup>

This was followed in 1850 by the development of the Hahnemann Medical Society, which met at 39 Bloomsbury Square in London on the first Tuesday of each month, and by the founding of The Homoeopathic Congress, which formalised the opportunity for all the homoeopathic practitioners in Britain to meet on an annual basis.

As the prevailing medical mood continued to swing against homoeopathy, further groups and associations were formed to provide support and solidarity for beleaguered colleagues. In July 1851, following a meeting of doctors in London, the Association for the Protection of Homoeopathic Students and Practitioners was formed.<sup>35</sup> This development had been stimulated by the action of the medical faculty at the University of Edinburgh, which had refused the degree of Doctor of Medicine to a candidate (Mr Alfred Pope), not because of academic failure, but because he refused to pledge that he would never practise homoeopathy. The association passed a series of resolutions designed to publicise the injustice, reverse the decision and organise future resistance.

In 1852 the Northern Homoeopathic Medical Association was instituted.<sup>36</sup> Its objective was to promote the advancement of medical and surgical science among members of the profession who were using homoeopathy. The annual subscription was five shillings (25p). At the end of 1873 the association had 34 members. Although a few of the doctors also belonged to the BHS, the great majority were practitioners whose work lay in the northern counties and who would have found regular travel to London difficult.

The Liverpool Homoeopathic Medico-Chirurgical Society, which had been founded in 1857, was also in this part of the country.<sup>37</sup> This group held its meetings at the Liverpool Homoeopathic Dispensary on the first Wednesday in each month from October to May. It numbered 12 members; again, most did not have dual affiliation, though one or two, like Dr Drysdale, were also associated with the BHS.

A further grouping for doctors in more distant regions was the Northumberland and Durham Homoeopathic Medical Association. Unfortunately, the relevant directory does not provide a membership list or give the date of formation, but the association must have been founded

sometime after 1853.<sup>38</sup> It met on the first Tuesday of each alternate month.

A similar lack of detail is available for the remaining traceable association in the 1870s, the Midland Homoeopathic Medical Society. This was centred on Birmingham, where meetings occurred in April and November. Eighteen doctors belonged to this group and, as before, only a minority were also members of the BHS.

By the 1870s, as already noted, there were well over 100 homoeopathic chemists practising in England, Scotland, Ireland and the Channel Islands. Often, pharmaceutical firms would be explicitly associated with particular hospitals or dispensaries. The chemists, however, had also grouped together, forming the Homoeopathic Pharmaceutical Association of Great Britain.<sup>39</sup> The objectives of the society were the development and improvement of homoeopathic pharmacy, the protection of members, the establishment of a library and the exchange of ideas between members.

Professional communication and identity, of course, were forged not merely through the meetings of associations and societies, but also through journals. In 1874 homoeopaths could subscribe to any of three major publications: the *British Journal of Homoeopathy*, a five shilling (25p) quarterly representing the official voice of the BHS, whose first number had appeared in 1843; the *Monthly Homoeopathic Review* at one shilling (5p); and the *Homoeopathic World*, which was also a monthly serial priced at four old pennies (roughly 1.5p). The *British Journal of Homoeopathy* was edited by doctors Drysdale, Dudgeon and Hughes, the *Review* by doctors Ryan, Pope and Nankivell, and the *World* by Dr Ruddock. In addition, doctors could buy the *Annals of the British Homoeopathic Society* for an annual price of five shillings and use the yearly *Homoeopathic Directory* as a useful reference work.<sup>40</sup>

The development of homoeopathy's dispensaries and hospitals played an important role in giving doctors an institutional focus for their identity, as well as access to a wealthy and prestigious clientele. They had helped, too, to provide education for aspiring homoeopaths. More or less formal programmes of lectures had always been offered at the Hanover Square, Hahnemann and London Homoeopathic hospitals, but it was not until 1876 that instruction was institutionalised when Dr Bayes founded the London School of Homoeopathy.<sup>41</sup> By that time the network of care offered by homoeopaths had been extended. Although the Hanover Square and Hahnemann hospitals had been closed for some time by the 1870s, the London Homoeopathic Hospital was still flourishing, and new hospitals had opened in Bath, Birmingham, Doncaster, Hastings, Manchester and Southport.<sup>42</sup> In addition the number of dispensaries had grown to 112, with



37 of these designated as 'public' (i.e. charitable) institutions and 75 as private (i.e. where some fees were charged and where management was undertaken by the medical officer rather than a committee of patrons).<sup>43</sup>

The growth and increasing density of this network of institutions was certainly a reflection of homoeopathy's burgeoning popularity in the middle decades of the nineteenth century, but, in some large measure too, it was the result of the raft of policies first instituted by the PMSA in 1851. Prior to that, homoeopaths would have been pleased to be regarded as legitimate and properly qualified practitioners offering a therapeutic speciality; afterwards, they were regarded as traitors who had forsaken the right to be part of the profession. The product of this ostracism, however, was a hardening of homoeopathic identities and solidarities. Concerted political action by regular doctors in the pursuit of specific occupational interests had thus succeeded in constructing new theoretical and institutional boundaries which had never been part of the original project of the BHS.

As homoeopathy's popularity began to wane towards the end of the century, however, regular opposition also began to relax. But by then professional isolation had become a way of life. The dwindling band of homoeopaths in the BHS seemed content to talk merely to each other – and, of course, to relax in the warm glow of the fees flowing from residual upper class patronage.

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**Notes**

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