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STEVEN J. NOVAK

PROFESSIONALISM AND BUREAUCRACY:
ENGLISH DOCTORS AND THE VICTORIAN
PUBLIC HEALTH ADMINISTRATION

Until recently, England's nineteenth-century revolution in government eluded historical analysis. The difficulty was not to trace the beginnings of the change but rather to explain how and why the proliferation of bureaucratic government happened as it did.¹ In the work of Oliver MacDonagh and his followers, historians found answers to these questions.² But while many historians embraced MacDonagh's conclusions as a new historical orthodoxy, certain ambiguities in his work remained unexplored. MacDonagh's belief that the evolution of bureaucracies followed an inherent pattern of development, an internal logic, regardless of external influences, implied that all bureaucracies are essentially alike and all bureaucrats are simply the passive agents of an irresistible process. The revolution in government was thus reduced to a mere evolution. Since the following essay departs from this interpretation and offers an alternative approach, a slightly more extended analysis of MacDonagh's thesis is required.

Seeking to uncover the practical functioning of government administration, MacDonagh chose the Passenger Acts for study because they were an isolated example. He justified this in words which bear repeating for the conceptual assumptions they reveal:

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Important for the purpose of a case study, emigrant protection is a comparatively simple and unadulterated subject. No Wilberforce or Shaftesbury, no Chadwick or Trevelyan, directed its reform. . . . No jealous local authority or powerful trade society succeeded here in holding back the tide of centralization and official regulation. All this makes it possible for us to study the indigenous development of government in as 'pure' and uncomplicated a state as is likely to be found.³

Clearly he was trying to distill the essence of bureaucracy from the accidental influence of external factors, trying to discover what might loosely be called the ideal type of bureaucracy. He regarded this type not as an abstraction—as a sociologist would—but rather as the essential reality of bureaucracy divorced from its accidental qualities.⁴ This core of bureaucracy was not only self-sufficient but also self-propelled.

Administration may be, so to speak, creative and self-generating. It may be independent, not in the sense of congealing into forms, but in the sense of growing and breaking out in character and scope. It may gather its own momentum; it may turn unexpectedly in new directions; it may reach beyond the control of anyone in particular.⁵

If MacDonagh meant only that change was sometimes unplanned and random, his assertion would go unchallenged. But this was a description not so much of how bureaucracy grew but why it did. Bureaucratic growth was not random at all, he maintained, but followed a five-stage model which underlay all of English centralization. The first stage was simply the passage of a remedial legislative act in response to the exposure of a social evil. Such acts were invariably ineffectual; hence, at the second stage, inspectors were appointed to enforce the law. At this point the process assumed its own momentum. To tighten loopholes, inspectors created an administrative board to centralize and strengthen control. As enforcement continued to be ineffective, government officers realized that the social evil could not be corrected once and for all but required flexible and continuous regulation. This realization was the fourth stage when "in place of a static and purely executive, they developed a dynamic, creative and expert concept of administration."⁶ During the fifth stage, this dynamic outlook was expressed: "There was now small concern about the multiplication on controls. As needs arose, they were simply

satisfied—in so far as legislation or instructions might serve this purpose.”⁷

The most important aspect of MacDonagh’s explanation is that bureaucratic growth is seen as continuous and almost inevitable. Once the process was set in motion, it followed the contours of its own internal logic. The telos of the process was progress. “Through it all ran what might be termed contingent necessity,—the ‘contingent’ being if emigrant protection [in general, social melioration] were to be realized.”⁸ Since inspectors were the agents of this realization and the shapers of the bureaucracies, it is important to recognize their motives and viewpoints. After all, men disagree on what constitutes progress and how it is to be achieved. For MacDonagh, however, such disagreement was irrelevant. Progress and administration were straightforward and obvious; his bureaucrats were faceless.

In fact, the whole process required little more than that men should have reacted reasonably intelligently to established facts, and with reasonable compassion for the suffering of others. . . . It is a safe assumption that things fell out in essentially the same fashion in many other areas of life.⁹

Should MacDonagh’s thesis be accepted unreservedly, this field of research will be narrow and dry indeed.

That the tendency of this theory is to standardize all bureaucracies can be seen in the work of Roy M. McLeod, whose study of air pollution inspectors reinforced all of MacDonagh’s conclusions, including the “now familiar legislative and administrative sequence of growth.”¹⁰ By treating his scientists as mere bureaucrats, McLeod missed the opportunity of discovering what impact their professional identity had on their behavior. This oversight was due to the common mistake of regarding science as a purely objective and disinterested authority. MacDonagh mentioned science only briefly: it was the authority “over which there could be no argument” called in to answer technical questions.¹¹ Another historian, David Roberts, has treated science as an irresistible force: “Each new [scientific] advance not only made reform possible but made it all the more necessary.”¹² And even one as skillful in probing beneath broad generalities as G. Kitson Clark wrote of “the unimpeachable voice of science.”¹³ These men committed the common fallacy of misplaced concreteness by

treating the abstraction science as though it were a physical entity which could act in its own right. Science is an ideal, a value, but scientists are mortals with their own interests to pursue.

By studying how such a mixed motivation spurred the medical profession's involvement in England's public health administration, one can discover the impact of professionalism on the course of bureaucratic growth and test the applicability of McDonagh's model. It seems entirely natural, of course, for doctors to be concerned with health, especially in a period when their inability to cure disease made it imperative to prevent it. Prevention required knowledge of living conditions, and the facts uncovered by investigators stirred England's social conscience. One historian, in an attempt to explain the medical profession's "passionate advocacy" of public health, has stressed the great number and influence of doctors who were graduates of Edinburgh University, where medical problems were set in a broad social setting.¹⁴ But while the idealism implanted by such education should not be discounted, it does not explain why doctors were not content to pursue their investigations and improvements at the local level or why their attention was often more directed to administrative politics than the everyday matters of disease prevention.

Previous writers have failed to appreciate that the medical profession looked to public health for a chance to enter the civil service.¹⁵ Medical journals spoke quite frankly of public health in these terms. "Is the profession . . . prepared to see *its position in the civil service of the State* reduced to a mere negation? We unhesitatingly answer, No."¹⁶ There were two reasons for this interest in civil service. First, like any professional body or trade union, the medical profession had to provide sufficient employment for its members, a need which may have been enhanced by changes in English society. One historian has contended that middle-class education in Victorian England expanded much faster than opportunities for suitable employment, producing fear of a glut in the professions.¹⁷ Whether or not this apprehension was well founded, it sparked a rivalry among professionals for positions of public service. Second, the factor which will be emphasized in this paper, doctors were interested in the civil service because they believed that state employment would raise the social status of the entire medical profession.

At least since 1823, when Thomas Wakely founded *The Lancet*, the most militant voice in the cause of professional advancement, doctors had been acutely sensitive about their position in English society. Wakely was angered to think that the profession, “though armed with the most righteous cause that ever nerved a great body of scientific men,” produced “no feeling of fear or apprehension in the minds of its enemies.” This was because of the profession’s “meekness and humility under oppression, because of the discordant opinions which its members have professed among themselves,—because, in a word, it is not true to itself.”¹⁸ Less than a decade later another organization was founded, the British Medical Association, and shortly thereafter its publication *The British Medical Journal*, both dedicated to the “Maintenance of the Honour and Respectability of the Profession.”

Status anxiety was also reflected in the continuous debate over medical education. Lyon Playfair, an M.P. with medical training, complained in 1874 that there was a “prejudice against technical knowledge” in English society. “This distrust of doctors in higher administration,” he said, “is simply a general mistrust of science. And the time has now arrived when science must be trusted in government.”¹⁹ Others reasoned that rather than change the prejudices of English society, doctors would have to acquire the traditional liberal education before being accepted as gentlemen. “I can see no reason,” wrote Dr. C.E. Prior, “that the amount of classical, mathematical, and historical knowledge required for entrance upon professional studies should be less than the moderate demands of our universities at matriculation.”²⁰ In order to achieve what one historian has described as “the professional ideal,” doctors had to stress their duties to the public and the general value of their training rather than their pecuniary interests or the fact that they were specialists who sometimes worked with their hands.²¹ But the pecuniary interests were nonetheless present. *The Lancet* condemned physicians who allowed their names to be used in drug and corset advertisements and asked “in all seriousness, . . . how can we expect the public to recognize the profession, by right, as a body of educated gentlemen, if we reduce ourselves to nothing better than a set of touting tradesmen?”²² This struggle for upward mobility was a constant preoccupation of doctors in the nineteenth century.

Such status anxiety was not limited to the medical profession. Victorian England was undergoing great social change, and men were obsessed with the problem of ascribing social status.^{2 3} Though the medical profession may have been rising on the social scale, it was still in an inferior relation to the other professions and its progress may have been slower than the others. In 1859 the *Contemporary Review* ranked the different professions and put the clergy, the bar, and the military on top; medicine was lower because it never led to the peerage.^{2 4} The reason doctors looked to civil service to raise their status was that connection with the state was one of the surest signs of a profession's social eminence.^{2 5} There was general agreement that the highest professions were those regulated by law and protected from unqualified competition. A writer in 1857 noted that the highest positions went to professions "more or less connected with the state" whose "importance is recognized by the law."^{2 6} And in 1880 another observer explained that "the professions in England are valued according to their stability, their remunerativeness, their influence, and their recognition by the state."^{2 7}

One sign of recognition was state regulation. Here the doctors did not fare too successfully as it took years for medical reformers to get minimum standards enacted for the profession. If Parliament was not enthusiastic about such an act, neither was it particularly opposed. After years of delay caused by divisions within the profession, a Medical Act was finally passed in 1858. The precedent of the act was more important than its provisions. It did not bar the practice of quacks but only set up a Medical Council which could establish minimum requirements for doctors who wished to be listed in the Medical Register. The Council could also suggest educational improvements to the medical schools. While the act was probably not responsible for raising the level of medical education, it did have a great symbolic importance to the doctors by suggesting medicine's increasingly important place in society.

A more substantial means of recognition was through state employment. There were doctors in the army and navy, of course, but the professional journals felt that these were treated with "unworthy disregard and disrespect . . . contumely and injustice."^{2 8} There were physicians to the Royal Family, but

doctors complained that these were never rewarded with a seat in the Lords but at best with mere knighthoods. An example of how thoughtlessly the government could slight the profession came as late as 1897 when Salisbury, who had just made Dr. Joseph Lister the first medical Lord, explained that this was for his scientific attainments rather than his medical services.

Thus, entrance into the civil service through the public health bureaucracy meant much more to doctors than an opportunity to improve England's health. To further their cause, doctors formed pressure groups such as the Epidemiological Society (1850), the Society of Medical Officers of Health (1856) and the more widely based Social Sciences Association (1857), which kept the profession in the thick of government debate by espousing the cause of public health.

The impact of this professionalism on the public health bureaucracy bears little resemblance to the processes in MacDonagh's isolated case study. For public health was controversial and bitterly contested, and its progress was halting and uncertain. From the doctors' point of view, the bureaucracy went through three stages: (1) from 1848 to 1854, when they struggled for entrance into the bureaucracy; (2) from 1854 to 1871, when they enjoyed a virtual monopoly in one area of public health; and (3) the years after 1871, when they lost their dominance of the administration but were eventually able to secure legislation which insured their place in the civil service. Rather than evolving according to its own internal logic, then, the public health bureaucracy was the result of the manipulation of the medical profession and was hence a distinct phenomenon, not just another example of MacDonagh's five-stage pattern of growth.

Doctors played a significant, though always secondary, role in the origins of the public health administration. Two utilitarian physicians, Dr. Neil Arnott and Dr. Southwood Smith, headed Chadwick's 1838 Poor Law Commission on the relation between poverty and disease, while Dr. William Farr provided accurate data for the study of disease. But it was Chadwick himself who dominated the beginnings of the public health bureaucracy.

Edwin Chadwick was a criminal lawyer by training. He became an intimate friend of Jeremy Bentham because of their common belief that wise legislation would bring social progress. Chadwick

had long been interested in the causes of disease, and his first published essay dealt with the French statistician Villermé's theory that health was directly determined by living conditions. Chadwick reproduced this theory in his 1842 publication of Victorian England's most famous blue book, the *Report on the Sanitary Condition of the Labouring Population*. Here he set forth the pythogenic theory of zymotic disease.

Various forms of epidemic, endemic, and other disease [are] caused, or aggravated, or propagated chiefly amongst the labouring classes by atmospheric impurities produced by decomposing animal and vegetable substances, by damp and filth, and close and overcrowded dwellings. . . . Where those circumstances are removed by drainage, proper cleaning, better ventilation, and other means of diminishing atmospheric impurity, the frequency and intensity of such disease is abated; and where the removal of the noxious agencies appears to be complete, such disease almost entirely disappears.²⁹

This report prompted Sir Robert Peel to set up a Royal Commission on the Health of Towns which ultimately led to England's first public health act in 1848.

There was nothing exceptional about Chadwick's theory of disease. The way in which he applied it, however, determined who should be included in the new bureaucracy. Though Chadwick held many learned professions in contempt, his greatest animus was reserved for medicine. He saw doctors' efforts as mere obstructions to the principles of health. Hence, when the new bureaucracy was set up, the role of medical inspectors was limited to ascertaining cause of death in order to provide accurate statistics. No doctor sat on the Board of Health. Chadwick relied instead on engineers to dispose of sewage and to provide clean water. "The chief remedies," he wrote in 1842, consist in "application of the science of engineering, of which medical men know nothing." To another he confided, "aid must be sought from the science of the Civil Engineer, not from the physicians."³⁰

Doctors were acutely conscious of their exclusion. When it was learned that no physician would sit on the Board, *The Lancet* complained that "the whole history of sanitary reform, as applied to the people at large, tells a tale of the grossest injustice towards medicine and medical men."³¹ "No government has a right," it said, "to convert a noble profession like that of medicine into an

underling.”^{3 2} Nor was the profession appeased in 1851 when a physician was finally added to the Board under the internments act. One doctor asked,

Who would have thought that in the last decade of advancing civilization . . . the whimsical experiment should have actually been tried of appointing three non-medical authorities—two Lords and a Barrister, to preserve the health of the living; and then, after a year or so of doubtful success, calling in a physician to bury the dead.^{3 3}

On the local level, while local boards were required to appoint inspectors of nuisances, medical officers were optional, an “absurd anomaly” according to *The Lancet*.

Rivalry between Chadwick and the doctors erupted during the cholera epidemic of 1849. With the exception of Dr. John Snow, who published his now famous but then unappreciated findings that cholera was a water-borne contagious disease,^{3 4} no one had any idea of how to treat the epidemic. As one doctor wrote to Chadwick, “in our profession, every new occurrence, an epidemic, or a new remedy, or an extraordinary case of disease, is attended by violent literary symptoms.”^{3 5} One physician attributed cholera to the action of magnesium salts in water; another lectured on “its dependence on the electric state of the atmosphere”; one sought a cure from an old Arabic manuscript; while another proposed treatment according to algebra.^{3 6} *The Lancet* carried articles proposing the use of sulphur, chlorine, calomel, bleeding, cold affusions, electricity, transfusions, mercury, oxygen, chloroform and common salts as cholera cures.^{3 7} This confusion is typical of what Thomas S. Kuhn has termed the crisis stage of a paradigm change, and doctors were in the midst of “a period of pronounced professional insecurity.”^{3 8} In response to their own self-doubts, doctors violently attacked the well-meaning dietary precautions published by the Board of Health, calling them a “scurvey publication.” Dr. Southwood Smith’s theories were termed “zymotic gibberish,” and Chadwick was portrayed as a “dictator” surrounded by “idle lawyers and busy-body parsons.”^{3 9}

Chadwick’s fall from power in 1854 was the doctors’ opportunity. Already in 1853 the profession had petitioned Parliament to appoint a Royal Commission on cholera, “directed by men of high *scientific* attainments . . . to discover the most *scientific*

methods of controlling the disease.”⁴⁰ The impact of the profession’s pressure was felt in 1855 when Sir Benjamin Hall, the new President of the Board, publicly declared himself against

the anomaly of leaving the General Board of Health without any permanent medical element and thus depriving the Board of all intimate connection with medical science and the medical profession.⁴¹

Hall appointed twelve doctors as medical inspectors and set up a Medical Council to investigate the epidemic. When Chadwick’s ambitious General Board of Health was dismantled in 1858, Dr. John Simon’s *Papers Relating to the Sanitary State of the People of England* introduced what has been called the era of state medicine. Simon, who replaced Chadwick as the central figure in public health, put forth plans for a central administration headed by a pathologist, manned by medical experts and dedicated to putting public health on a firmer scientific footing.⁴²

Dr. John Simon, whose Medical Officership to the Privy Council followed Chadwick’s General Board of Health, was perhaps England’s most powerful advocate of medical reform and professional advancement. He was a firm believer in science and at first perceived his task as organizing medical research rather than compelling cleanliness. His small staff of medical inspectors were restricted to gathering and publishing data and giving advice to only those communities which asked for it. After the controversy aroused by Chadwick’s regime, Parliament was glad to give the doctors free play, thereby meeting demands for sanitary reform without offending the water companies and local boards of guardians who had a vested interest in the status quo. For the doctors, the Medical Officership was a state-subsidized research grant which symbolized the state’s need for medical expertise. Their activities always served the dual purpose of advancing both public health and the medical profession, illustrating Kuhn’s assertion that “the members of a scientific community see themselves . . . as the men uniquely responsible for the pursuit of a set of shared goals.”⁴³ Indeed, Simon was unable to distinguish the interests of the public from those of the profession, and in the early years of his administration “Simon’s office and the professional pressure groups were barely distinguishable in personnel and policy.”⁴⁴ In order to convince the government that only doctors

were qualified to supervise public health, he sometimes purposely exaggerated what he termed the “peculiarly technical nature of our business.” His desire to manipulate the politicians also explains the “almost ostentatiously scientific character” of his inspectors’ reports.^{4 5} By pushing the interests of the profession too far, however, Simon unwittingly undermined his own authority. Because their functions sometimes overlapped, a rivalry had grown up between the Local Government Act Office and Simon’s Medical Officership. To end this conflict, Simon effected a behind-the-scenes administrative coup in 1869 which gave medical inspectors primacy over other government officers and limited the Local Government Act Office to cases where doctors determined that legal actions were required. With their duties thus enlarged to include bookkeeping and enforcement, as well as research and advice, medical inspectors were put in the position of seeking to monopolize every aspect of sanitary administration. By “boldly seizing the initiative for the doctors, by ensuring that the new health superintendence should be primarily medical,”^{4 6} Simon placed doctors in the indefensible position of pretending to possess sole qualification for such mundane tasks as haggling with local authorities and supervising clean-up operations.

Doctors also pressed Parliament for more stringent public health laws. Sanitary legislation had evolved without coherence or uniformity; departments and officials overlapped; laws were unevenly enforced; authorities frequently differed. Half buried beneath the excitement of the American Civil War and election reform, public health found its only sponsors in the medical profession. Here the commonplace but too often forgotten moral of Mandeville and Adam Smith must be remembered: that selfish behavior is often beneficial to society. In the 1860s, in any case, the doctors’ agitations produced positive results. In 1868 the British Medical Association and the Social Science Association founded a Joint Committee to push for sanitary reform. Drs. H.W. Rumsey, A.P. Stewart and W.H. Michael persuaded the government to create a commission to review the sanitary state of the country.

The commission included some of the most prominent medical men of the country: Thomas Acland from Oxford, James Paget from Cambridge, Sir Thomas Watson and Drs. Christison and Stokes. Acland and Christison testified before the Commission, as

did Simon, Rumsey, six medical officers and several other doctors. As might be expected, their testimony endorsed medical dominance of the public health bureaucracy. Rumsey said that Simon's Office had "done more for the cause of public health than any public body in this country, and that, therefore, it is the very best of all departments to be at the head of sanitary action."⁴⁷ Local administrators, he continued, should be medical men with special qualifications. Simon agreed and urged that medical officers with special training be mandatory for every district. Acland stressed the highly technical nature of medicine.

In the highly developing and highly developed state of chemistry, of anatomy, of physiology, and of toxicology, and with the immense mass of knowledge now collected in the department of forensic medicine, it is practically idle to suppose that a man, because he might be a good curative general practitioner, was necessarily an expert, capable of solving all the questions which might be raised in courts of law on any of the subjects that I have just named.⁴⁸

It all sounded so intimidating that Rumsey had to tone down his comments by assuring his listeners that "I would particularly guard against the idea that I wish to institute a medical despotism in this country."⁴⁹ To the non-medical witnesses, however, this seemed an apt description of what was happening. Arnold Taylor of the LGAO testified that a lawyer or an engineer could perform day-to-day business and inspections.⁵⁰ John Lambert of the Poor Law Board and Lord Penrhyn denied that medical officers were needed at all and claimed that Poor Law doctors could be used in the few cases which required medical opinion.⁵¹

When the Commission's recommendations were passed into law, as the Local Government Act of 1871 and the Public Health Act of 1872, the doctors won most of their points. But just as the profession's influence seemed greatest, a twist of fate undercut the power of the doctors. The new acts merged public health with the Poor Law Administration and put them under the Local Government Board. When the government decided that the Board's president should be a politician, Simon and his inspectors, who had been a small but virtually autonomous department, found themselves in uncomfortable subordination to officials who were often unsympathetic to their aspirations. James Stansfeld, the first

president, seemed determined to block the profession's ambitions; and if his actions contained little real fire, they caused a great deal of smoke.

First, Stansfeld ignored Simon and his staff. Medical officers were given neither a voice in shaping policy nor encouragement in pursuing research. As *The Lancet* lamented, "It may almost seem as if the Medical Department created by the Privy Council is to be sacrificed."^{5 2} After repeated frustrations, Simon handed in a bitter resignation in 1876; and for years the place of the chief medical officer remained at issue between the profession and the government. Linking this complaint to their desire for heightened prestige, doctors called for a Minister of Health who would have a permanent seat in the Cabinet. Trying to fulfill the profession's highest ambition, one doctor speculated,

It would be as consistent to give him a seat for life in the House of Lords as it has been to find a similar seat for the Bishops of the Church; or, to give a more recent illustration, for the two Life Peers who have been taken from the legal profession to assist the Upper House in its deliberations.^{5 3}

When a Minister of Health was finally created, however, he was chosen from outside the profession. And not until 1919 did the chief medical officer gain even the status and pay of a Permanent Secretary to the Minister.^{5 4}

Second, Stansfeld refused to enforce a provision in the public health acts which required that full-time medical officers be assigned each district. Some local boards of guardians sidestepped this requirement by hiring physicians part-time at annual salaries of £10 to £60.^{5 5} Others passed the duties of sanitary inspection on to the Poor Law doctors. Medical officers did not have powers of compulsion and remained subordinate to the guardians. Such part-time advisory roles were in direct conflict with the doctors' standards of professionalism.

The greatest ire, however, came when Stansfeld appointed ten lawyers to serve as mediators between the central board and local authorities. This was seen as

an unheard of, almost an infamous thing, that lay inspectors should have been appointed to supervise the work of medical men who have passed medical examinations, and possessed medical knowledge and skill. It was really an insult to the profession.^{5 6}

One journal advised its readers to “lose no time in individually and collectively offering their strenuous resistance [to the] offensive and insulting administration of the act.”⁵⁷ The other journal concluded that doctors must enter politics so that

the decision of these questions should be duly influenced by *the most learned of the professions*, and not left, as of aforetime, to the considerations and guidance of *pettifogging attorneys and tipling publicans*.⁵⁸

Stansfeld’s administration, which Simon termed “a policy of retreat,”⁵⁹ has been attributed either to incompetence or to hostility toward the medical profession. One medical officer said,

If it was unfair to say of him [Stansfeld] that he knew about as much of science as a cow does of conic sections, it is yet undeniable that at that time he failed to appreciate the possibilities of preventive medicine and the importance of dealing in a comprehensive fashion with the public health of the country.⁶⁰

And Simon’s biographer portrayed Stansfeld as the tool of Edwin Chadwick and Florence Nightingale, the doctors’ staunch enemies.⁶¹ But several of Stansfeld’s actions belied this supposed anti-medical bias. Just before taking office, he was instrumental in raising Simon’s annual salary from £1,500 to £2,000, making him England’s highest paid civil servant. And in the 1880s, he co-operated with Lyon Playfair to redistrict medical areas in order to make feasible the profession’s long-sought demand for full-time medical inspectors. Furthermore, Stansfeld’s retirement did little to boost the position of the medical inspectors. Roy M. McLeod has described the later years of the bureaucracy in an article entitled “The Frustration of State Medicine.”⁶²

Stansfeld’s own explanation for his policies contained considerable common sense. He told the Commons that he had “no intention of committing the whole sanitary administration of this country to medical men.” The goals of “sanitary protection,” he said, “were cleanliness and purity; and they did not want medical men to effect that.”⁶³ Since no specialized medical knowledge was required to lay a drain or collect refuse, he advised the doctors that:

To maintain the authority of the scientific man, and to secure for him respect and even popularity, it was necessary to reserve him for occasions when there was a sense that his special knowledge and services were needed.⁶⁴

According to J. Donald Kingsley, a similar attitude pervaded English society.

The expert in the Civil Service is a sort of stepchild, regarded without enthusiasm by his administrative colleagues. For the underlying assumption in the service as well as outside is the natural superiority of the amateur. This is a point upon which the members of the specialist classes are not a little sensitive—and some of them even rather bitter—and it explains in part the friction between them and the members of the Administrative Class.⁶⁵

Why Stansfeld frustrated the doctors is less significant than the fact that his policies did not jeopardize England's health. This reversal in the authority of the doctors has a bearing on MacDonagh's theory of bureaucratic development. His description of administration which required "little more than that men should have reacted reasonably intelligently to established facts" cannot adequately explain the doctors' self-interested pursuit of public health. And his assertion that "contingent necessity" underlay the course of bureaucratic growth is refuted by Stansfeld's policies which proved that medical dominance of public health was not a prerequisite of successful administration. As will be shown below, doctors simply did not have sufficient knowledge or skills to offer an alternative to the program of cleanliness carried out by Chadwick or the Local Government Act Office inspectors. Sanitary science was still in a rudimentary state. Hence, when doctors monopolized public health, it was not due to the results they had achieved or to their deeper comprehension of disease; it was due to their success in "selling" medicine to the government.

When struggling with Stansfeld, the doctors attempted to strengthen their position in the bureaucracy by stressing their specialized functions and further elaborating their technical credentials. But when Simon's effort to monopolize public health proved ill-fated, the doctors retreated with the air of aloof expertise. Dr. Rumsey advised inspectors:

Carefully avoid poking your noses into your neighbors' sinks and dust-bins. Leave sewerage to the engineers, cesspool to the surveyors, pigsties and stale fish to the nuisance officers. Keep your test-tube and your microscope mainly for the diagnosis of disease.⁶⁶

Dr. Michael reminded his colleagues:

The medical officer of health is not the inspector of nuisances, and should be careful not to arrogate to himself functions which belong to another officer and which could only be exercised in derogation of his own proper status and authority.⁶⁷

Dr. Buchanan, who succeeded Simon, envisioned the ideal medical officers as “an army of scientific watchmen . . . intent upon discovering the hidden workings of the causes of disease.” But as *The Times*, though sympathetic to the profession, was forced to observe, “in the present state of the medical profession Dr. Buchanan’s watchmen have not only to be found but have also to be educated to their work.”⁶⁸ Here was the rub. It was not by “contingent necessity” that doctors had advanced in the public health administration but by their strenuous self-promotion. Had medical men really possessed all the specialized skills they claimed, their legitimacy as experts would never have been questioned. But though they could hardly admit it to themselves, they did not yet have such skills. Hence, to justify their place in the civil service, they could only create an artificial body of experts—doctors with the form but not the reality of technical expertise. If my interpretation is correct, this differentiation of knowledge and function was not the natural result of scientific advances but rather an artificial means of insuring the continued recognition of doctors in the civil service.

Although doctors did not regain control of the bureaucracy, they did guarantee their place in it. In an 1886 amendment to the Medical Act, they obtained official permission to grant diplomas in public health. And two years later an amendment to the public health act stipulated that henceforth medical officers would have to be “holders of a diploma in sanitary science, public health, or State medicine.”⁶⁹ Specialization was now officially recognized, as the result of a determined campaign by the profession.

The first demand for special diplomas in state medicine was made by Dr. Rumsey to the Medical Council in 1868. In 1874 a special committee of the British Medical Association called Parliament’s attention to “the special characteristics of State medicine, as contrasted with those of ordinary curative medicine.”⁷⁰ When the government repeatedly failed to act, Dr. Ransome complained that its indifference to the qualifications of medical officers made it seem “as if it had been the intention of our Government to

degrade the office of State Physician as much as possible.”⁷¹ He proposed that every candidate for public health be required to pass through a special college. In 1877, the Joint Committee on State Medicine and the Social Science Association petitioned Prime Minister Disraeli to the effect that “all officers of health should be debarred from private practice and be holders of diplomas in State medicine.”⁷²

Before special diplomas could be mandatory, medical schools had to bestow them. In 1874 the University of Edinburgh was the first to grant post-doctoral certificates in public health. By 1878 the universities of Cambridge, London, Durham, Glasgow and Dublin had followed suit. These diplomas were given for passing an examination in chemistry, physics, statistics, public health laws and theories of pathology.

Whereas in 1869 doctors had confessed that “the work has still to be written which should be made a textbook for students of State Medicine.”⁷³ suddenly there was a great rush to publish. The first real textbook was Dr. Edward Smith’s 1873 *Manual for Medical Officers of Health*. Five years later Dr. Cornelius B. Fox brought out his thorough *Sanitary Examinations of Water, Air, and Food, A Handbook for the Medical Officers of Health*. Numerous publications fell into an indeterminate category—partly technical, partly historical, largely exhortative. Pure popularizations of preventive medicine were Dr. Parker’s book *Public Health* (1876) and Benjamin Ward Richardson’s *Health and Life* (1878).

It might appear that this proliferation of knowledge was due to the new germ theory of Pasteur and Koch on the Continent which made possible the discovery of precise causes of disease and the inoculation of patients against them. But, on the contrary, England’s creation of public health experts occurred in almost total isolation from these scientific breakthroughs. Not until the end of the century were the new findings accepted in England.

Dr. Fox’s text considered every possible cause of disease—from emanations to meteorological conditions. Disease remained for Simon an environmental condition. Simon championed Max von Petterkofer’s theory that cholera was determined by the water level of the subsoil.⁷⁴ In his reports of 1865 and 1866, he concluded that “excrement-sodden soil, excrement-reeking air, excrement-tainted water, there are for us the causes of cholera.”⁷⁵

The profession failed to advance beyond Chadwick's old theories. Doctors continued to believe that breathing foul air caused disease. Diphtheria, yellow fever, typhus and cholera were classed as "zymotic diseases," which one doctor described as "excremental pollution diseases," caused by "drinking water and breathing air contaminated by it in a state of decomposition."⁷⁶ Simon's biographer was forced to admit of the medical officers:

Their most usual long-term recommendations—sewerage and pure water—represent no advance on those made by the General Board's inspectors; and as for precise etiological knowledge of some major diseases like scarlet fever and diphtheria, Simon confessed himself almost equally in the dark as his predecessors.⁷⁷

"Uncleanliness must," wrote Simon, "be reckoned as the deadliest of our present removable causes of disease."⁷⁸ But though doctors reverted to Chadwick's beliefs, *they were now giving diplomas for this knowledge*. It is in this sense that they were innovators, experts in form but not reality. Differentiation resulted solely from the medical professional's social aspirations.

Though the doctors succeeded in pushing their way into the civil service, in two respects their effort was a failure. The transparency of their ambitions caused considerable resentment in government circles which added to the prejudice against medicine in England. The Principle Clerk of the Treasury, for example, accused the Medical Department of going "far beyond any reasonable action" in its investigations and of trying to "set up a department of State Medicine which would be enormously costly and of which they of course would be the exponents." His correspondent agreed that in comparison with the engineers, who had work thrust upon them by Parliament, "the Medical Department have rather courted work with a view of creating a Department of State Medicine."⁷⁹ The doctors also failed in their attempt to discover the causes of cholera and other contagious diseases. It was a blow to their patriotism as well as their professionalism to have Continental scientists beat them to these discoveries. Even though they blamed the state for its shortsighted neglect of research, it is doubtful that their attempt to mix scientific investigations with routine duties of administration was well suited to producing a major scientific breakthrough.

But if the impact of civil service on the medical profession was disappointing, the force of professionalism was a major factor in shaping the public health bureaucracy. And here is where Mac-Donagh overlooked one of the major influences on the revolution in government, by focusing primarily on the stages of growth and by assuming that these stages were required for successful administration. The energy required to change English society was not due exclusively to impersonal forces such as industrialization or urbanization. Scientists, engineers, doctors and lawyers all used the civil service as a means of promoting their own interests. Because doctors had a vested interest in public health, Simon was right in his conclusion:

For the further development of our sanitary institutions and their working, the educational onward impulses may be expected to come pretty continuously from members of the Medical Profession, and are perhaps not in any essential sense to be expected largely except from these.⁸⁰

Although self-interest played its part, the idealism of doctors should not be slighted. Preventive medicine became almost a religion to doctors, and they saw themselves quite literally as a new clergy. In place of theology, Richardson spoke of the “higher principle of prevention.”⁸¹ Millennial visions crept into the last pages of Simon’s *English Sanitary Institutions* where the principle of prevention was extended to social relations. In his speech, “A Homily, Clerico-Medical,” Richardson asserted that there was little difference between ministers of the body and ministers to the soul.⁸² “It sometimes appears to us,” wrote *The Lancet*, “that the State, as it tends to sever itself more and more from theology—as it clearly does—tends to connect itself more and more with Medicine.”⁸³ Thus it was no exaggeration when Herbert Spencer charged in the 1892 edition of *Social Statics* that “there is an inclination on the part of the medical profession to get itself organized after the fashion of the clergy. Little do the public at large know how actively professional publications are agitating for State-appointed overseers of the public health.”⁸⁴ Spencer knew from experience that professional zeal was a dynamic element in the course of bureaucratic growth.

FOOTNOTES

1. The beginning, for convenience sake, is marked by the Factory Act of 1833, which provided the first permanent inspectors, and by the Poor Law of 1834, which created the first central board with supervisory powers over the counties.

2. Oliver MacDonagh, "The Nineteenth-Century Revolution in Government: A Re-appraisal," *The Historical Journal*, I (1958), 52-67. For a good survey of later investigations see Gillian Sutherland, "Recent Trends in Administrative History," *Victorian Studies*, XIII (1970), 408-11.

3. Oliver MacDonagh, *A Pattern of Government Growth, 1800-60, The Passenger Acts and their Enforcement* (London, 1961), pp. 7-8.

4. The distinction is made in Max Weber, *The Theory of Social and Economic Organization* (New York, 1964 ed.), p. 109, though I think Weber claimed too much for sociology.

5. MacDonagh, "The Nineteenth-Century Revolution in Government," op. cit., p. 53.

6. MacDonagh, *A Pattern of Government Growth*, op. cit., p. 345.

7. Ibid.

8. Ibid., p. 346.

9. Ibid., p. 9.

10. Roy M. McLeod, "The Alkali Acts Administration, 1863-84: the Emergence of the Civil Scientist," *Victorian Studies*, IX (December, 1965), pp. 111, 112.

11. MacDonagh, *A Pattern of Government Growth*, p. 329.

12. David Roberts, *Victorian Origins of the British Welfare State* (New Haven, 1960), p. 103.

13. G. Kitson Clark, *The Making of Victorian England* (Cambridge, Mass., 1962), p. 104.

14. M.W. Flynn, introduction to Edwin Chadwick, *Report on the Sanitary Condition of the Labouring Population of Great Britain* (Edinburgh, 1965), pp. 22, 18-26. This is a thoughtful and detailed summary of the background to Chadwick's report. Flynn's assertion that Chadwick was not prejudiced against doctors is based on events prior to the competition for positions in the General Board of Health and is not necessarily accurate for these later years.

15. My use of the phrase "medical profession" is intended to include the most articulate and outspoken promoters of the profession but not to imply that the profession was more united than it actually was. Leadership was hotly disputed between the Medical Council, created by the 1858 Medical Act, the British Medical Association and the medical schools. But conflict was not over what should be done but over who should do it. All three groups sought educational reform, state regulation and entrance into the civil service. Because each group espoused medical dominance of public health, my use of the term "profession" includes all of the major spokesmen of the English doctors.

16. *The Lancet* 1873:2, p. 158. Italics added.

17. See F. Musgrove, "Middle-Class Education and Employment in the Nineteenth Century," *The Economic History Review*, 2nd series, XII, 99-111; H.J. Perkin, "Middle-Class Education and Employment in the Nineteenth Century: A Critical Note," *The Economic History Review*, 2nd series, XIV, 122-30; and F. Musgrove, "Middle-Class Education and Employment in the Nineteenth Century: A Rejoinder," *The Economic History Review*, 2nd series, 320-29.

18. *The Lancet* 1844:1, p. 659.
19. *The British Medical Journal* 1874:2, p. 461. Charles Newman's standard *The Evolution of Medical Education in the Nineteenth Century* (London, 1957), is insensitive to the social implications of education. This neglect is corrected in S.W.R. Holloway, "Medical Education in England, 1830-1858: A Sociological Analysis," *History*, XLIX (Oct. 1964).
20. *The British Medical Journal* 1868:2, p. 82.
21. Sheldon Rothblatt, *The Revolution of the Dons, Cambridge and Society in Victorian England* (London, 1968), pp. 86-93. See also G. Kitson Clark. op. cit., pp. 258-74.
22. *The Lancet* 1858:1, p. 318.
23. G. Kitson Clark, op. cit., p. 253.
24. Quoted in W.J. Reader, *Professional Men, the Rise of the Professional Classes in Nineteenth-Century England* (New York, 1966), pp. 149-51. For professional demands that a doctor be made a Lord see *The Lancet* 1858:2, p. 558; 1872:1, pp. 339, 340; and *The British Medical Journal* 1876:1, pp. 93, 182.
25. Reader, *Professional Men*, p. 23.
26. H. Byerly Thomson, *The Choice of a Profession* (1857), quoted in Reader, *Professional Men*, p. 149.
27. T.H.S. Escot, *England: its People, Polity and Pursuits* (1885), quoted in Reader, *Professional Men*, pp. 150, 151.
28. *The Lancet* 1860, quoted in Reader, *Professional Men*, p. 65.
29. Quoted in E.N. Williams, *A Documentary History of England*, vol. 2 (1559-1931) (Baltimore, 1965), p. 239.
30. Quoted in S.E. Finer, *The Life and Times of Sir Edwin Chadwick* (London, 1952), p. 218.
31. *The Lancet* 1848:2 (October 21, 1848), p. 457.
32. *The Lancet* 1848:2 (September 9, 1848), p. 294.
33. Dr. Rumsey's *Essays on State Medicine* (1856) quoted in W.M. Frazer, *A History of English Public Health, 1834-1939* (London, 1950), p. 48.
34. *On the Mode of Communication of Cholera*, 2nd edition (London, 1855).
35. *Dr. Sutherland to Chadwick, 1848*, quoted in R.A. Lewis, *Edwin Chadwick and the Public Health Movement* (London, 1952), p. 193.
36. Ibid.
37. *The Lancet* 1849:2, Index pp. 708, 709.
38. Thomas S. Kuhn, *The Structure of Scientific Revolutions*, 2nd ed. (Chicago, 1970), pp. 67, 68.

39. *The Lancet* 1849:2, pp. 129, 458.

40. *The Lancet* 1853:2, pp. 439, 393.

41. Draft of a letter from Hall to the Treasury, August, 1855, quoted in Royston Lambert, *Sir John Simon, 1816-1904, and English Social Administration* (London, 1963), p. 229.

42. Many of my criticisms of MacDonagh's thesis were suggested to me by a careful reading of Lambert's detailed biography. For the most part, however, Lambert accepted MacDonagh's model as fully applicable to his data. "I owe much," he wrote, "to Dr. MacDonagh's remarkable and pioneering researches into the self-generating processes of governmental growth" (p. 169n). He saw public health as carried along by an "internal dynamic," though he noted that it was often in danger of termination, met much opposition, and continued largely because of the pressure placed on the government by the medical profession. In one telling passage he admitted that the bureaucracy was shaped by the doctors and not vice versa. "Simon's large personality, his *a priori* notions and ambitions, his idiosyncrasies make the development of the Medical Department only a partial exemplification of the trend of government growth so excellently analyzed by Dr. MacDonagh" (p. 460n). But he followed this admission with another reaffirmation of MacDonagh's model and used the scheme throughout the biography.

43. Kuhn, op. cit., p. 177.

44. Lambert, op. cit., p. 302; see also pp. 314, 315.

45. Lambert, op. cit., p. 292; see also 437.

46. Lambert, op. cit., pp. 421-23.

47. *First Report of the Royal Sanitary Commission* (1869) (London, 1870) Irish University Press ed., p. 235, query 4303.

48. Ibid., p. 320, query 5682. Note how specialized even the general practitioner sounds.

49. Ibid., p. 240, query 4376.

50. Ibid., p. 55, query 886.

51. Ibid., p. 262, query 4732; and p. 419, queries 4877-4880.

52. *The Lancet* 1873:2, p. 158; see also *The British Medical Journal* 1874:1, p. 178.

53. Benjamin Ward Richardson, *A Ministry of Health* (London, 1879), p. 27.

54. Lewis, op. cit., pp. 195, 196. Lambert, op. cit., p. 610.

55. *The Lancet* 1872:2, pp. 66, 360.

56. *The British Medical Journal* 1873:2, p. 192.

57. *The British Medical Journal* 1872:2, p. 13.

58. *The Lancet* 1872:2, p. 642. Italics added.

59. John Simon, *English Sanitary Institutions*, 2nd ed. (London, 1897), p. 392.

60. Herbert Preston-Thomas, *The Work and Play of a Government Inspector* (Edinburgh, 1909), p. 50.
61. Lambert, op. cit., p. 522 and passim.
62. Roy M. McLeod, "The Frustration of State Medicine, 1880-1899," *Medical History*, XI (Jan. 1967), pp. 15-40.
63. *Hansard*, 3rd series, ccxii, col. 1268.
64. *The Times*, January 12, 1875, p. 7.
65. J. Donald Kingsley, *Representative Bureaucracy. An Interpretation of the British Civil Service* (Yellow Springs, Ohio, 1944), p. 175. See ch. 8.
66. *The British Medical Journal* 1872:2, p. 282.
67. *The British Medical Journal* 1873: 2, p. 650.
68. *The Times*, October 20, 1875, p. 9.
69. *Parliamentary Papers*, 1888, IV, 155.
70. *The British Medical Journal* 1874:2, pp. 244-46.
71. *The British Medical Journal* 1877:2, pp. 214-18.
72. *The British Medical Journal* 1877:2, p. 247.
73. Quoted in Roy M. McLeod, "The Anatomy of State Medicine: Concept and Application," in F.N.L. Poynter (ed.), *Medicine and Science in the 1860s* (London, 1968), p. 215. McLeod's article is an important overview of different conceptions of state medicine.
74. Simon, *English Sanitary Institutions*, pp. 261-63, 287, 465.
75. Quoted in R. Thorne Thorne, *On the Progress of Preventive Medicine in the Victorian Era* (London, 1888), p. 58.
76. *The British Medical Journal* 1879:2, p. 220.
77. Lambert, op. cit., pp. 431-32.
78. John Simon, *Filth Diseases and their Prevention* (Boston, 1876), p. 12.
79. F.A. 'Court Bergne to William Culley (n.d., ca. April 20, 1887); William Culley to Welby April 21, 1887, quoted in McLeod, "The Frustration of State Medicine," p. 25.
80. John Simon, *English Sanitary Institutions*, p. 474.
81. Benjamin Ward Richardson, *The Future of Sanitary Science* (London, 1878), pp. 36, 37.
82. Benjamin Ward Richardson, *A Ministry of Health*, op. cit., ch. III.
83. *The Lancet* 1870:1, p. 14. Note that this was written before Stansfeld headed the administration.
84. Herbert Spencer, *Social Statics* (1892 ed.) and *Man vs the State* (New York, 1913), p. 202.