

Introduction

Victorian medical men could suffer numerous setbacks on their individual paths to professionalisation, and Thomas Elkanah Hoyle's career offers a telling exemplar. Hoyle was the son of a surgeon and the brother of another in his native Lincolnshire, was registered with the General Medical Council (GMC) in 1859, and married the following year.¹ He worked as a public vaccinator and poor-law district medical officer up to 1864 and died at a rather young but respectable age of fifty-nine.² Taken as a potted biography, this represents the outline of a modest but solid career. It is contradicted, however, by reference to alternative sources for a history of a medical professional, namely the local press and the records of the Lincolnshire County Lunatic Asylum. Hoyle's career was anything but secure. He had bought into his father's practice, but was effectively bankrupted by his parent in 1862.³ His marriage broke down in the same year following threats of violence to his wife, and this appeared to inaugurate a pattern of aggressive behaviour.⁴ Ultimately, in 1873 after an affray at an inn, he was admitted to the Lincolnshire Asylum where the case notes amplify his history of *de facto* alcoholism and sense of persecution. At the heart of his distress was a sense of infringement on his medical identity. He accused unnamed 'detectives' of having stolen copies of *The Lancet* from his railway luggage, and of 'talking about him in the town to injure his character'.⁵

Hoyle offers a concentrated vignette of 'medical misadventure' in the sense it is construed here. Men might benefit from all of the traditional markers of professional success, including inheritance of an established practice and GMC recognition, plus attributes of Victorian middle-class masculinity including a respectable marriage, and still have fallen short. Admittedly Hoyle was probably disadvantaged or disturbed by

his father's example – Hoyle senior was also a practitioner and had faked his own abduction and murder in 1845 – but the two different accounts of his life illustrate the positive ways that even problematic medical careers might have been read in the past.⁶ A better understanding of the professionalising process in medicine requires attention to halting and truncated careers.

This book addresses a range of the financial, professional, and personal challenges that faced and sometimes defeated the aspiring medical men of England and Wales. Spanning the decades 1780–1890, approximately from the publication of the first medical directory in 1779 to the second Medical Registration Act in 1886, it considers both their careers in England and Wales, and in the Indian Medical Service.⁷ These years saw the practitioners of orthodox medicine shift from a self-defined group loosely or barely represented by London Colleges and Companies to a self-conscious profession asserted and recognised by specialist publications, collective organisations, regulated training, public service, and the law. Duty to observe the boundaries for membership of the group, particularly in respect to tests of competence, was balanced by recognition of the value of autonomy over working practices and investment of public trust. Consequently, this era was an age of economic opportunity and social aspiration for professional men across different medical specialities. Yet opportunity was no guarantee of upward social mobility for all who sought it in a highly crowded market, and fear of failure was sometimes the prelude to actual failure. Jeanne Peterson wrote of medicine nearly forty years ago that 'Shared occupational status meant shared problems and joint efforts'; but not all problems were shared, and not all careers were transformed in positive ways.⁸ Therefore, unlike other histories of the profession, what follows is a sustained consideration of the career turbulence, disappointment, and curtailment that beset some men who were not able to secure full advantage from professionalising trends.

Practitioners were not unique among the professions more broadly in risking or suffering forms of failure. All of the same negative phenomena might beset representatives of the other learned professions, or men pursuing aspiring occupations which were moving towards professional status during the nineteenth century. Lawyers, for example, were much more likely than doctors to be declared bankrupt, and bankers struggled in their moves towards a 'newly confident ideal of professional

morality.⁹ Yet medical men experienced these forms of failure in some professionally specific ways. In particular the twin pressures of professionalisation and a persistent and highly competitive medical market for medicines and expertise had profound consequences for specifically medical forms of masculinity.

Similarly, Scottish, Irish, continental European, and extra-European practitioners were not immune to failure either. The importance of Scotland and Ireland in supplying men to the British medical profession is very well established, so the decision to concentrate on England and Wales may look misplaced. What is more, some notably lurid medical crimes were played out in the wider British context and made a strong negative impression on public perceptions of the profession as a whole.¹⁰ Nonetheless, the legal and structural differences distinguishing medical careers lived out beyond England and Wales imposed their own methodological constraints, such as their different legal systems and contrasting poor laws.¹¹ Therefore, Irish and Scottish practitioners do feature here but only where their turbulent careers were played out in England and Wales, or (in the case of Chapter 2) among English and Welsh colleagues in India.

The study of medical 'failure' within these parameters construes failure as central to the professionalisation process. Medical professionalisation was not exceptional in any respect: failure is the rule in any social project but, as in other spheres of inquiry, it has only been considered in passing in the history of medicine as a temporary staging post on the route to success. Failure needs to be reconceived 'as itself serving to direct and shape the process of governance', in this case the imposition of new occupational norms.¹² Only by appreciating the ubiquity and experiential features of failure can we recognise the specific functions it performed.

Professionalisation, reform, and legitimation

Medical professionalisation in this period went hand in hand with drives for reform.¹³ Most formally trained practitioners were agreed that a priority for the reform agenda was the eradication of quackery; however, beyond this goal reform meant different things to different parts of the sector in different decades. Debate arose in part because orthodox practitioners could not agree on what quackery comprised, but consensus

also foundered on the best strategy for legitimating medical authority. Recommendations for reform action from within cited variously occupational representation, education, and raising professional status, all of which were plausibly susceptible to statutory definition. Countervailing pressures from without held that only market deregulation and eradication of privilege could hope to set the seal on professional power.¹⁴

Medical journals were at the forefront of disseminating calls for reform. For Thomas Wakley and *The Lancet*, or at least *The Lancet* of the second quarter of the nineteenth century, reform entailed the formation of a self-disciplined meritocracy and the eradication of occupational advantage based on wealth and nepotism.¹⁵ Other periodicals tended to be more placatory, but the absence of a homogeneous tone was not necessarily a significant problem for medical journalism *per se*; practitioners going into print at any angle of the reform debate found 'a means of signalling their occupational ascendancy and establishing their legitimacy as professionals.'¹⁶ Together, the journals supplied medical men with a combination of updated medical knowledge and information about the options for reform, while their existence reassured the lay public of the norms and competencies of orthodox medical practice.¹⁷

Regulation of medical education lay at the heart of the reform project. Reformers wanted to take the intelligence of aspiring practitioners and, with the right educational structures, fashion their scientific medical expertise and examine them in rigorous ways. Awkwardly, these intentions had to map onto a shifting notion of where expertise lay. Educative primacy was shifting in the period 1750 to 1825 from ancient texts to dissection, observation, and clinical experience, preferably by walking the wards in a teaching hospital.¹⁸ Medical education became the subject of lay scrutiny in a Parliamentary inquiry of 1834 and one anticipated advantage of public interest, it was hoped, would be a decline in justified accusations of malpractice. Yet the timing was wrong for the fulfilment of any such hopes; from the 1830s onwards, the pressures of service introduced by the New Poor Law meant that rank and file practitioners struggling with individual pride, heroic workloads, and structural disadvantage ran up against charges of neglect and consequent dismissal from public office as a matter of routine.¹⁹

Moves towards professional oversight of medical education went hand in hand with an enhanced reputation for medical science, where

each benefited from the other. By the mid nineteenth century, Michael Brown argues that 'medical men had come to think of themselves as scientific professionals'.²⁰ While the status of science itself was not assured, the symbiotic relationship between intellectual command and specialised inquiry was theoretically advantageous.²¹

In addition to purely occupational reform, some recognised the necessity for practical *social* legitimisation: 'professional authority, however defined, rests on more than professional assertion ... it requires some measure of cultural acceptance as well'.²² A disinterested personal investment in the advance of knowledge and public service, quite aside from pecuniary gain, was an essential component of any reformist vision that looked beyond the confines of medicine to wider public support. Honourable service in the best interest of patients was tendered in exchange for interpersonal trust and professional privilege in law.²³ Uncomfortably, as medical aspirations encompassed a fully professional identity that was beyond reproach, men were caught up in the requirement to assert irreproachability while simultaneously striving to deserve the label.²⁴ The rhetoric of disinterest came to have a strong hold on the profession by the end of the period, but it is more questionable whether the majority of practitioners felt secure in their professional identity by the same date. Also, the rhetoric had an uncertain impact on day-to-day practice, both in relations with poorer patients and in instances of professional rivalry. Self-sacrifice and treating the poor without charge was all very well in theory, but there was the strong temptation to give less regard to pauper patients, particularly in the promotion of collective rather than individual professional gains. Anatomy Inspector George Cursham, for example, reproached the moral punctiliousness of a house surgeon in Manchester who made sure that poor patients were aware of their right to avoid dissection; he thought this conduct unbecoming to a medical professional.²⁵ In this instance, then, professionalism was unequivocally allied with interest and with concealment of the provisions of law.

Yet medical status was not wholly or necessarily tied to medical ideologies and behaviours around vested interest or the cultivation of disinterest. Historiographical perceptions of medical status have fluctuated instead around expertise and statutory recognition. Early works saw professional authority as an extension of specialisation and scientific advance, which Foucault refined as a translation of knowledge into

overweening power.²⁶ Latterly, historians have stressed instead provisionality, uncertainty, and discontinuous advance. Ian Inkster has argued that medical men had no established social status up to 1850, but Michael Brown sees the second decade of the nineteenth century as formative.²⁷ The increasing role for medical witnesses in insanity trials would seem to locate the 1830s as critical in cementing practitioners' legal status.²⁸ Even so, Roberts identifies the 1858 Medical Registration Act and the thirty years that followed as pivotal to the increase in lay respect for and deference to medical authority. He attributes this to three developments, namely the capacity of the GMC to contain intra-professional dispute, a perception from outside medicine of potential scientific advances to come, and a rebalancing of professional attributes to acknowledge the value of patient interpretation.²⁹ This book confirms the importance of the third quarter of the nineteenth century, and particularly the 1860s, in fostering lay respect, but also points to additional background cultural trends in perceptions of medical practitioners as integral to changing perceptions; 'the process by which the medical men achieved this respect encompassed so much more than medicine', and certainly more than successful medical practice.³⁰ Respect was manifested in different ways specific to the locality or decade, and not just on the plausibility of claims to authority but on the substantial investment of a non-medical public in medical claims of social status.

By the late 1880s, the concept of the professional medical man had acquired numerous potential attributes. These did not all necessarily have to be represented in one man, but individuals needed to display a suitable range to qualify. Criteria included education and qualification by recognised bodies, membership of learned or professional societies, holding public office, subscription to dedicated journals, and espousing values indicative of participation in a collective community of doctors. This concept was forged in the face of considerable internal difficulty and dissent, generated by a dilemma at the heart of medical practice. Yet disinterested professional judgement was jeopardised on a daily basis by the need to make a viable living.

Markets, ethics, and professional honour

To appreciate the intensity of this dilemma, it is important to consider the dimensions of the medical marketplace.³¹ At the end of the eighteenth

century, this market comprised a mixed bag of orthodox practitioners, irregulars who did not make their whole living from medicine, quacks, and sellers of patent medicines. Without falling into the error of thinking that all participants in the marketplace were ideologically alike, it is necessary to reflect on the impact of orthodox practitioners' dependence on fee income. To date, the impact of this dependence has been construed fairly generally or within a tight time-frame, and with the emphasis on prosperity.³² Mary Fissell has argued that around the late eighteenth century there was a sense that something valuable had been lost to professional medicine, in that commercialisation had undermined medical manners.³³ More recently, Michael Brown has taken issue with the dominance of marketplace narratives and has offered instead a picture of a co-operative, sociable profession, where attitudes only hardened in the second quarter of the nineteenth century.³⁴ This book establishes that there was certainly a new urgency to intra-professional relations and economic motivations by the 1830s, and that marketplace relations were not wholly superseded by 'professionalisation' at any point in the nineteenth century. What is more, visions of the market have been one-sided and culturally narrow; we can understand much more about failure to make money, about other forms of failure, and about the experience of fear in advance of such failures.³⁵

Market concerns persisted because, throughout the period 1780–1890, medical integrity was founded on a paradox: it was a necessity for practitioner–patient relations that clients' best interests (and not money) were presented as the prime motivator for medical men. Norms of professional demeanour developed in such a way as to promote prestige for medical altruism but undermine receipts of hard cash. Actions expressive of largesse, that restrained practitioners from demanding payment from impoverished patients for example, or which prompted them to offer their services *gratis* to a local institution, were widely adopted.³⁶ As Anne Digby has shown, institutional affiliation conferred status while establishing a man's credentials as a trusted practitioner and a selfless citizen. It also advantaged men who were intent on keeping their rivals out of the public eye.³⁷ At the same time, money patently remained essential and of abiding interest to men who were, among other things, self-employed entrepreneurs.³⁸ What changed across the period was the increasing gentlemanly imperative to suppress any allusion to medical incomes beyond guarded

occupational circles. Separation from a physical shop counter became important for self-perception, and doctors were not alone among medically related fields in this attempt to shed 'a commercial rather than a professional morality'.³⁹ However, by 1890, most practitioners remained unsalaried or regarded any paid position as a channel for private practice rather than a sole professional outlet. Payment by fees required extension of credit and dignified trust in clients, which inevitably meant short-term cash-flow problems and entrenched difficulties in reclaiming outstanding debts.⁴⁰ At the same time, any public expression of concern about fee income became repugnant, and remained so into the twentieth century.⁴¹

Other sorts of conflict might be used to disguise fee competition. Medical disagreements about therapeutic utility were notionally acceptable or even a necessity when multiple consultations were the right of the patient.⁴² Practitioners theoretically acknowledged the requirement for discretion over arguments about honourable practice and etiquette, but in reality discretion only lasted until the individuals concerned decided that public exposure was unavoidable or at any rate in their interests. Disagreement typically generated responses of disquiet and generalised calls for restraint. *The Lancet* suggested a labour-intensive model for medical tribunals to resolve points of etiquette, with little effect.⁴³ Avoidance of the implications of quarrels between practitioners, and their wider significance for the profession, stretched well beyond 1890.⁴⁴ Protecting and augmenting one's private patient list was certainly a constant throughout the period covered here.

Medical reformers recognised the social disadvantage of public enmity; an early president of the Provincial Medical and Surgical Association confessed a hope that 'jealousy and hatred, that unseemly speck and blemish, shall [be] washed from the fair face of our humane and charitable profession'.⁴⁵ Public unanimity and expressions of personal disinterest became explicit goals for medical practitioners, and the pressure to maintain appearances intensified from the mid nineteenth century. From 1858, the GMC was formally charged with reprimanding or striking off practitioners found guilty of attracting patients, and this included advertising, canvassing, and deprecation of colleagues.⁴⁶ The distinction between advertisements and 'public announcements' was a subtle one, and collective self-policing of sly promotional agendas became increasingly vocal.⁴⁷ Yet these intentions were drastically at

odds with the broader occupational and social context: 'The Victorian bourgeois world was highly competitive.'⁴⁸ Consequently, most if not all organs of medical journalism were complicit in forms of personal or group advancement; alluding to the *British Medical Journal*, for example, James Mussell has concluded that 'all of its textual spaces belied the myth that professionals did not advertise'.⁴⁹

From the patients' perspective, there was a long history to suspicions that medical practitioners were periodically guilty of avarice or self-advancement. Hard evidence is anecdotal and chronologically dispersed, as much evident from attempts by doctors to counter these impressions as from clear-cut cases of profiteering.⁵⁰ It was hardly surprising, though, if practitioners' concerted drive to present themselves as professionally disinterested accelerated patient expectations. It is difficult to avoid the conclusion that medical men unwittingly set themselves entirely unachievable standards in this respect that might provide a goal which could never decisively be reached. Throughout the chapters that follow, medical ideals on marketplace behaviour and other matters are often seen to be untenable.

The paradox of 'interest' in promoting or undercutting medical professional and social legitimacy underlay the emergence of medical ethics, and so provided an additional source of personal conflict for practitioners.⁵¹ Traditional sociological literature about the professions confirms that the ethical practitioner-client relationship will be built on a form of trust absent from the relationship between buyer and seller. Since the professional enjoys the advantages of knowledge and skill, which the client is not competent to judge on the grounds of equal knowledge and skill, the latter is vulnerable to exploitation. Internally enforced integrity minimises this risk and enhances professional trust.⁵² Early nineteenth-century medicine did not follow the 'internal integrity' model very closely. Historians have recently been debating whether medical ethics were largely or wholly viewed as coterminous with professional duties, and chief among these duties were the obligations owed to other professionals.⁵³ The ethic of collegiality over-rode ethical duties to patients.⁵⁴ This book analyses the fates of practitioners who struggled to manage their collegial duties in relation to their own and their patients' best interests. The strain of surviving as 'competitive entrepreneurs who also shared remarkably strong communal loyalties', or at least aspired to share them, was acute.⁵⁵

Such loyalty, in the form of occupational solidarity, was most confidently expressed in opposition to competition from irregular practice, and while the historiographical focus on opposition to quackery has rested on the period up to 1858 it continued to supply a regular presence in medical journalism throughout the 1860s. As the threat of quackery receded it was supplanted by the prospect of competing with female practitioners. Clare Brock has pointed to the complicated response of medical commentators to university training for women as indicative of a lack of security in the masculine profession.⁵⁶ Female practitioners represented on one level the unwelcome introduction of a new sort of non-traditional (if not entirely 'irregular') competitor for medical work that threatened male incomes, but vocal opposition to female students, activists, and qualified practitioners risked a different sort of social detriment. Men who were too keen to denigrate female medical aspirations risked displaying a passionate and public form of self-interest that was both ungentlemanly and increasingly seen as unprofessional. The protectionism of practitioners was nothing new, but the scope for its expression or defence was narrowing across the final quarter of the nineteenth century.⁵⁷

By the 1880s, practitioners' occupational competence and personal integrity were inseparable, the former fostered by education and regulated by statute, with policing devolved to the GMC, and the latter by the gentlemanly etiquette and self-command required of a self-regulating profession from within and without.⁵⁸ The result was a notionally exacting prescription for medical behaviour that demanded men be not only skilled but also friends to their patients and united with colleagues.⁵⁹ In defending his brother Joseph's posthumous reputation, Thorold Rogers may well have overstated his case, but he claimed that the professional doctor was held to higher standards than other men, eschewing evident rivalry with colleagues and being required to be wholly open on matters of treatment; 'It is no easy matter to win position and fortune in a calling which is regulated by the strictest rules of professional honour.'⁶⁰ Rogers was tacitly recognising the enhanced tensions between the still-active medical marketplace and the multiple emergent yardsticks of professional conduct.

Ironically, no amount of punctilious politeness towards fellow medical people and apparently open-handed disinterest towards patients *could* have insulated the profession from continued external

suspensions of unethical conduct and mercenary motives, but in any event such perfection was not forthcoming.⁶¹ Ongoing expression of divergent sentiments, on a spectrum from disquiet at professional differences to choked fury at professional trespasses, generated satirical, angry, or fearful lay responses. Divisions in the profession over the Contagious Diseases Acts, for instance, inspired outrage in the repeal campaign towards medical supporters of the Acts.⁶² What was more, an impression of smooth public unanimity risked a different sort of reproach, in the form of strident criticism for professional arrogance as seen for example in the searing anger expressed in Frances Power Cobbe's 'The Medical Profession and Its Morality' in 1881.⁶³ The fraught relationship between medical finances and ethical behaviours proved impossible to navigate for some if not most men, and created disastrous conflicts for a minority. The external pressures to expunge open competition with colleagues, in addition to only partial success, led unsurprisingly to the development of means for covert competition between practitioners. Covertly competitive behaviours were a feature of both 'the hard pressed rank-and-file' and the more established members of the profession.⁶⁴ They also induced an additional stress, fear of exposure, at the same time that the imperatives of middle-class masculinity sought to govern the range of men's acceptable expressions.

Manliness and medical masculinity

The same decades that saw the 'rise' of the medical profession also witnessed an intense focus on what it was to be appropriately masculine. Prominent ideas about stereotypical or hegemonic manliness from the late Georgian to the late Victorian periods altered substantially and with surprising speed. In the eighteenth century, masculinity had been generated or undermined by politeness and social performance. In the late century this was inflected by the notions of sensibility, whereby easy verbal sociability was increasingly modulated by displays of sympathetic feeling.⁶⁵ The early nineteenth century saw masculinity become more strongly associated with privacy than sociability. The inherent superficiality of politeness was supplanted by a serious and purposeful manliness, characterised by personal integrity and expressed by direct, succinct or even taciturn interaction with peers.⁶⁶ In turn this required an altered attitude to domestic life; 'Men's stance towards the home was

influenced not only by the particular web of relationships they found themselves in, but by their sense of what was right and proper for themselves as men.⁶⁷ Experience of family was varied, as individual men either extolled homeliness or were defeated by its demands, but in either case the relationship with the domestic was key and potentially disciplinary.⁶⁸ In the longer term, though, the *rejection* of home became definitional. In the second half of the nineteenth century, muscular Christianity was purveyed by British public schools and the school story giving rise to even secular athleticism; 'a neo-Spartan ideal of masculinity was diffused throughout the English-speaking world'.⁶⁹ By the end of the period the rhetorical emphasis had shifted to distance from home, whereby 'images of frontier manliness were fed back into the metropolis' to foster militarism, stoicism, and discipline among British boys and men.⁷⁰

Practitioners of medicine either aspired, or emphatically belonged, to the middling sort and later the middle class throughout the late eighteenth and the nineteenth centuries. The evolution of medical masculinity across the period was therefore dependent on the consolidation of particular types of authority, some of which derived from middle-class householder or gentlemanly status – 'good practitioners must "feel and act as gentlemen"' – but where others were specifically medical in tone.⁷¹ In terms of middle-class norms, John Tosh and others have argued for the centrality of the domestic sphere and an ideological allegiance to the values of domesticity for middle-class, mid-Victorian manliness. This gave precedence to marriage, not as a right but as a goal to struggle towards; to 'form a household, to exercise authority over dependents, and to shoulder the responsibility of maintaining and protecting them – these things set the seal on a man's gender identity'.⁷² The production or recruitment of dependents in the form of children and servants extended the remit of his control. Therefore, financial stability and (after marriage) sexual continence were as much a part of the medical persona as they were that of other middle-class professionals.

The additional, personal qualities which were essential to the successful medical man as a gentleman went beyond the external enactment of propriety and demanded an equal commitment to appropriate internal states.⁷³ These included the mindset born of 'breeding, and a cultured education'.⁷⁴ This looked beyond the merely masculine mind to foster a properly manly mind, comprising an intellectual power that

was presented as beyond the reach of most adult men. These ideas crystallised in the 1880s in the social-Darwinist writings of Edward Cope, Karl Pearson, and George Romanes among others: as Boddice explains 'The manly mind was ... not simply a scientific reinforcement of the opposition between the sexes, but an expression of extreme exceptionalism, in which only a small coterie of select men were fitted by natural law to lead, invent, philosophise, judge, and generally be at the vanguard of progress. All of society fell in behind the gentleman.'⁷⁵ By the end of the period, the pressure was decisively on professional and medical men to occupy this elite social and intellectual space, as well as to fulfil the demands of middle-class masculinity more broadly.

Further medical inflections on masculine status derived from a shared experience of training, work-life identification, and pursuit of occupational fulfilment. This entailed not just collective participation but also ideological commitment and an appropriate expression of ambition – energetic but honest. One physician thought medical men were perhaps best placed to secure 'the attainable portion of the Divine Idea', in preference even to clergymen, arising from doctors' combination of duty and practical benevolence.⁷⁶ Medically specific knowledge, skill, and vocational fervour were adjuncts to both the public and domestic persona, since a medical identity entailed being always on duty, not being a slave to work but wholly fulfilled by it.⁷⁷ This meant that a practitioner's family was dependent on him for physical health in addition to safety and financial security, and that the public had a right to expect medical assistance to be proffered in public emergencies. In the ongoing overlap between medical work and the practitioner's own home, there was a less rigid boundary observed between work and domestic spaces than was (notionally at least) emerging for other trading and professional people, because home and surgery typically occupied the same premises.⁷⁸ What was more, other people's homes comprised doctors' occupational contexts and 'their destination was perhaps the most unprofessional and gendered of all spaces: the bedroom.'⁷⁹ Did this complex relationship with the domestic damage practitioners' ability to become fully engaged with mainstream bourgeois culture?⁸⁰ Medical men might feel that it did, even where lay people were prepared to excuse them for domestic evidence of professional activity, and masculinity in other professions like education may also have suffered from an 'inherently critical relation to conventional

domestic arrangements.’⁸¹ At the same time there was a risk that practitioners would fail to find the succour at home that was available to other middle-class men because they could not view home as a refuge from professional demands.⁸² Participation in both private tragedies and famous cases took their toll on practitioners’ peace of mind.⁸³

The later Victorian period brought additional challenges. Muscular Christianity’s implied disparagement of the feminine conflicted with the medical role as carer. Attentive, almost doting, concern was idealised for practitioners in cultural formats, most obviously perhaps in the painting ‘The Doctor’ by Luke Fildes, which significantly was first exhibited in 1891. Here the doctor waits anxiously and almost wistfully at the bedside of a child patient, where otherwise the child’s mother might sit; the mother is relegated to the background.⁸⁴ Such professional tenderness and stillness was essentially irreconcilable with the physical action and emotional stoicism associated with *fin-de-siècle* manliness.

Just as early historians of masculinity queried the deforming force of stereotypes and ideals, we can by extension consider the potentially deforming nature of medical professional manliness.⁸⁵ The same process of estrangement from complex individual identities placed discernible and sometimes unbearable pressures on men, meaning that they could not sustain the required image either in their own eyes or according to external markers. This was the price paid for forging an authoritative professional identity by the late Victorian period, and some men fell short, although the visibility of their shortcomings depended quite heavily on the willingness of the lay public to acknowledge them.

Falling short

The combined forces of professionalisation and the evolution of manly identities were enormously challenging, and opened up new possibilities for failure. Recognition of ‘failure’ across the late eighteenth and nineteenth centuries arguably shifted from perfunctory and occasionally comic to complex and serious. In the Victorian period, ‘Failure was, perhaps unsurprisingly, a significant preoccupation of an age fascinated with success.’⁸⁶ Financial failure was treated most prominently, but the era was highly attentive to different forms of failure in all walks of life and all stages of a career.⁸⁷ In medicine, the combined imperatives of

professionalisation, the market, and medical masculinity together constructed a mutable but stringent ideal, which was the object of many but the attainment of rather fewer. Medical careers and personal lives rarely ran so smoothly as to permit a steady acquisition of multiple positive attributes without delay or interruption. Students might fall at the first clear hurdle, namely by failing their examinations or falling prey to examination stress. Once secure in their qualifications they might struggle to obtain a remunerated post. The strains of juggling private practice, public responsibility, domestic solvency, and personal ambition could and did wreak havoc on individual men's physical and mental health, and prompted hundreds of medical suicides.⁸⁸ The evolution of a professional ideal ensured the emergence of its antithetical counterpart, giving rise to the anxious, overworked, disappointed or fearful practitioner, who could not consistently withstand the pressures imposed by their professional and personal goals.

Failure could in theory be given a positive cast, in the close ideological proximity between striving, failing, and potential greatness; as influential author John Ruskin put it, 'no great man ever stops working till he has reached his point of failure'.⁸⁹ Defeat could be faced bravely, and so supply an opportunity to augment the masculine identity rather than undermine it.⁹⁰ Browning's 'aesthetic of failure' found supportive echoes in Victorian biography which placed 'emphasis on the quiet heroism and courage present in perseverance in the face of failure'.⁹¹ But Victorian biography tended to be written posthumously, inevitably some time after shortcomings are realised. It was much more difficult to secure such dispassionate sympathy in the immediate aftermath of crushed hopes, self-reproach or public exposure. Localised expressions of support can be inferred in the case of men who suffered financial disaster, where their recovery and return to practice can be proven, and were palpable in the face of accusations of serious sexual crime. Other sins took longer to mitigate or might never be redeemed.⁹²

Naturally, failure and success were never fixed entities, and the attributes of the professionalising process meant that the criteria for either state were constantly shifting. The spectrum of difficulty encompassed financial, occupational, personal, and legal grounds, and each variety of misfortune might be experienced as either mild or acute, short-lived or permanent. At the same time, the moral basis for blame over failure was calibrated by context: an innocent mistake could be exonerated where

a wilful error was reproached, but the definition of either depended very heavily on the construction of the failing by family members, peers, and lay observers, and from one decade to the next. Finally, the extent to which a person fell short was partially measured by their personality and character in advance of the fall. In this way, both self-conception and public reputation contributed to the perceived severity of failure. Historical analyses of failure *versus* success are therefore hedged about with qualification and can only be pursued using some fairly crude markers. The best that can be said of those markers is that they strive for internal consistency of application over relatively short periods.

Historians of medicine have paid only very modest attention to 'acknowledgement of failure'.⁹³ Historians began by considering the difficulties of establishing an income with the related threat of financial failure.⁹⁴ Treatments of other forms of failure were piecemeal, suggestive of closure rather than opening up a new field of inquiry.⁹⁵ Even Brown, who problematises traditional marketplace readings of the social history of medicine, highlights failure in the eighteenth century but does not extend the possibility forward into the nineteenth. He observes that 'For every fabulously wealthy practitioner ... there were literally hundreds of others who either eked out a meagre existence, or fell by the wayside.'⁹⁶ What of these hundreds of men and, more importantly, what of their generational successors?

Medical men fell short of expectations inadvertently or intentionally, in private or exposed to public criticism. The most emphatic (but not necessarily the most personally damaging) public disappointment was probably removal from the *Register* of the General Medical Council after its first publication in 1859. The GMC adjudicated on 160 professional conduct cases up to 1890, but commentators have agreed that this is a poor indicator of 'medical sin'.⁹⁷ Financial considerations and/or fear of losing credibility have inhibited the Council from drawing all potential cases into its remit.⁹⁸ Also, the nineteenth-century cases were not always framed to undermine a medical identity decisively. Statutory misconduct around false certification (of births and deaths, qualifications, vaccination or for the purposes of elementary education) could be dismissed as accidental or as technical infringements that were not permanently discrediting.⁹⁹ Finally, deregistration was not necessarily irrevocable as re-registration applications were heard favourably from

the 1870s.¹⁰⁰ Therefore, those men who were selected for investigation and were struck off functioned as a small subset of 'bad apples', removed to demonstrate the functioning of the system and provide reassurance about the competence and rectitude of practitioners remaining on the list.

The most common form of public inadequacy, where specifically *medical* reproach was only implied rather than explicit, was that of financial failure in the form of either insolvency or bankruptcy. Far more medical men were caught up in one of these processes than in any of the other forms of career turbulence considered here. Both procedures were a matter of public record, advertised nationally in the *London Gazette* and then excerpted for the provincial press. Medical bankrupts and insolvents may be found throughout the period 1780 to 1890, but in much greater numbers after 1820. As a consequence, Chapter 1 considers the full span of years but the case studies of individual men are concentrated within 1805–55.

Personal perceptions of falling short, which undercut the medical masculine identity beyond that of financial provider, are more difficult to uncover. Given the necessity to be wholly fulfilled by one's career, it seemed important to consider thwarted ambition; men who aimed high patently did not always secure the illustrious professional paths they sought. Expressions of regret, disappointment, frustration, or depression may be found across the period and across occupational labels and specialisms, but here they have been gathered specifically from men whose careers took them overseas in the service of the East India Company. Extensive global travel supplied an obvious and inevitable career interruption to men who were born and trained in Britain, but also seemed liable, at first glance, to attract men whose opportunities had been narrowed or evaporated elsewhere. An older historiography frequently repeated the claim, for example, that military or naval service recruited the less well-qualified practitioners.¹⁰¹ While this was often an unjustified slur, it does suggest a concomitant experience on the part of medical men, that they were reluctant or regretful that their skills might not secure them a better or more lucrative practice. Army and navy doctors, though, have enjoyed a recent resurgence of interest, while literature on the Indian Medical Service is yet to be substantially updated.¹⁰² Therefore Chapter 2 addresses medical service in India from 1780, but stops short in 1858 owing to structural

alterations to governance, recruitment, and the terms of service after that date; additionally, the surviving narrative sources for medical men compel closest attention to private perception of disappointment in the decades 1810–40.

Falling short in public, in terms of gentlemanly demeanour or professional competence that did not necessarily generate GMC action, is more difficult to locate. Public censure without formal criminal prosecution was a common experience of alleged failing, and for purposes of this research it was most often visible in the verdicts of Victorian coroners' courts and the unofficial riders given to verdicts by indignant juries. In this way, many more men were caught up in public reproach as a consequence of their work for Poor Law Unions than were ever investigated by professional or lay searches for justice.¹⁰³ Therefore the chronology observed in Chapter 3 of necessity concentrates in the years after 1834 and the Poor Law Reform Act.

Men who chose to fall short in one area in order to maintain their status in others were explicitly or unintentionally testing the boundaries of viable medical identities and behaviours in order to serve their own best interests. Personal preference and a sense of asserting the power of the group might even align in some instances: it has been suggested by Milligan that a rising phenomenon of medical opium addicts in the late nineteenth century can be traced to a collective desire to assert authority over the drug, and addiction enjoyed the advantage of privacy in both its practice and treatment.¹⁰⁴ At the other end of the spectrum of exposure, the most scandalous and public were those cases where practitioners were prosecuted for murder. A handful of cases have been repeatedly surveyed in both historical and popular literature, with Palmer the Rugeley poisoner leading the way towards Dr Crippen in the early twentieth century.¹⁰⁵ Yet these cases have provided a narrative of lurid exceptionalism on the part of doctors, when in fact they should rather be seen as part of a continuum of violence emanating from the legitimated bodily invasions of medical practice.¹⁰⁶ By consulting less infamous cases of medical prosecution for both murder and serious sexual assault, all of which happen to fall after 1840, Chapter 4 uncovers unexpected potential in allegations of wrong-doing, both for shaping the medical profession and responses to it from without.

From a more domestic and personal perspective, individuals' masculinity was challenged by barriers to householder and breadwinner

status, particularly in the form of chronic illness: doctors might be patients too. Most bodily illness among middle-class families was managed privately and gives rise to highly dispersed notice in the historical record, but mental illness was different in that it prompted institutional admission of patients across the social spectrum. Medical men were admitted to nineteenth-century asylums in significant numbers, and their case notes reveal an array of detail about the way that professional drivers interacted with poor mental health and underlay the occasional breakdown of doctors' home lives.¹⁰⁷ By these means, Chapter 5 is able to consider the *de facto* surrender of household authority and medical identity inherent in such admissions for the years when asylum case notes survive, starting with sporadic reports in the 1820s through to clumps of evidence in the 1870s and 1880s.

The fear of opprobrium stemming from cash crises and the risk of mental imbalance from any cause were in some cases so severe that they precipitated suicide. Practitioner suicide plainly took place in all decades, so the rise in reporting seen after 1840 is as much a function of newspaper practice as it was an indication of intensifying stress. Even so, Chapter 6 does not present a static picture; the ramifications of doctors killing themselves intensified for both profession and public, such that one specific death in December 1882 became a national scandal.

The chronological parameters for each variety of falling short dealt with in successive chapters will vary, partly in accordance with the availability of the underlying sources but also with changes to the law and the significance with which contemporaries invested each failing. These fluctuations damage the ability to chart change over time in relation to each form of failure. Bankruptcy offers the most consistent and lengthy coverage, but here changes in the law render a declaration in 1780 very different to its equivalent in 1890. Topics are typically considered in most detail from 1840 onwards. Collectively, however, the overlapping chronologies at work in each chapter compile a picture of medical misadventure with key pressure points across the nineteenth century.

An unexpected feature of this picture is the emergence of the 1860s as a notably precarious decade for medical reputations, and this echoes findings elsewhere beyond the historiography of medical professionalisation. Sheila Sullivan has identified this decade as critical for both displays of masculine failure and the consequential development of a

professional masculine identity. She deploys evidence from men's writings, including sensation novels, to argue that the phenomenon of sensationalism was profoundly interested in 'the failures of supposedly normal men'.¹⁰⁸ By rendering failures 'spectacular' such writing contributed to the consolidation of a new, authoritative form of masculinity invested in professionalism, 'which is gradually freed from its mooring in specific jobs to become the qualities that allow Englishmen to exercise power from a variety of positions'.¹⁰⁹ Attributes such as financial disinterest, control of the energetic self, and control of women's bodies, are all germane to this realignment. Doctors' presentation and self-presentation in the newspaper press can offer confirmatory narratives for this process, played out in the public and sometimes 'spectacular' coronial and criminal courts.

Methodology, digitised newspapers, and occupational terms

To explore the scope for medical men to 'fall short' of their own or others' expectations, this book conducts a species of cohort study where different, overlapping, cohorts provide a series of foci depending on variant types of career turbulence. The majority of these cohorts have been defined by close analysis of late eighteenth- and nineteenth-century newspapers for doctors suffering financial failure, allegations of wrong-doing, or suicidality. Newspaper reports were hardly neutral in that they were active participants in generating scandal, by flagging unconventional behaviour and so guiding public perceptions of, in this case, practitioners who fell short in public.¹¹⁰ In turn, lay reporting of medical career turbulence contributed to 'setting the agenda for public and private discussion', and consequently the negotiation of professional status or modification of medical conduct.¹¹¹ The account written from such research is therefore partly concerned with cause and effect, but is more attentive to how different types of story functioned. At the same time it heeds Bingham's call for more research on newspapers' construction of gender, in this case specifically medical masculinity.¹¹²

Recent online publication of digitised newspapers means that it is now possible to search extensive bodies of text for genres of information which would otherwise remain hidden in plain sight.¹¹³ The main database used here is the British Library Newspapers resource hosted by Gale.¹¹⁴ Newspapers enjoyed diverse constituencies of readers across

England and Wales (including London but very far from confined to it), so a database which included metropolitan and provincial journals appealing to both elite and popular readerships was essential. The titles incorporated in the British Library collection range from the London daily *Morning Post* to the much more popular Sunday publication *Lloyds Weekly Newspaper*, and across numerous county and city periodicals.¹¹⁵ This database has the advantage of permitting proximity searches, making location of relevant material much more precise. It also helps to mitigate the risk of the (hitherto) distorting predominance of *The Times* in historical enquiry.¹¹⁶

Nonetheless, it is important to acknowledge the limitations of the British Library Newspapers database. The most significant generic warning for the purposes of this research was that 'The accuracy of optical character recognition (OCR) software is (quite literally) hit and miss.'¹¹⁷ Another fundamental characteristic of the database is its instability and partiality. It initially comprised forty-eight or forty-nine newspapers with different spans of extant copies, but has been augmented such that at the time of writing, parts II, III, and IV contain an additional twenty-two, thirty-five, and twenty-two titles respectively.¹¹⁸ When the bulk of the research for this book was completed, part II was available via institutional university library subscription but parts III and IV were not. This means that a protracted research timetable will give rise to different numbers of crude hits at the start and end of a project, but at no time will the research given in the following chapters include hits from newspapers digitised for the third and fourth phase of the database. Furthermore, all hits will remain fewer on the British Library Newspapers database than they would on the British Newspaper Archive which comprises over seven million newspaper images but which, unlike its counterpart, is not licensed by JISC and so is currently viewable only at the British Library or via subscription.¹¹⁹

Identifying relevant men entailed devising a list of occupational labels that might reasonably hope to sweep up all of the practitioners deemed by most contemporaries to be formally qualified, or *en route* to formal qualification, but with the proviso that some labels put health workers beyond the reach of the project. 'Physician' is generally a reliable indicator of professional inclusion. 'Surgeon' is more equivocal given the number of potential occupations which integrated the term. Dental surgeons, veterinary surgeons, and others whose professional

trajectories differed significantly from that of formal medicine were excluded. 'Doctor' required similar care; doctors of laws, economics or divinity were disregarded. The most generic term was 'medical', since this prefix was used to identify medical men, officers, gentlemen, students, assistants, and practitioners.

Medical assistants were not always or decisively professionals, but their presence here is thanks in some measure to Arthur Dix. Dix was a surgeon in Stourbridge in Worcestershire who came from a good Northamptonshire family and had been sent to Oundle public school but was admitted to the Worcester asylum in 1863.¹²⁰ Asylum personnel ascribed his violence and self-aggrandising ideas to his over-consumption of opiates and spirits: 'he has for some time past taken 36 grains of Morphia in 24 hours. His habits have been active but intemperate and vicious.'¹²¹ Gradual improvement in his symptoms allowed him to be discharged after three and a half months, but he was subsequently admitted to the St Andrew's asylum in Northamptonshire for two months in 1865.¹²² Dix's career was substantially disrupted by his poor mental health, such that by 1871 he had removed from Worcestershire to Hampshire, and his occupational designation had been downgraded from surgeon to assistant.¹²³ In other words, the assistant's role might be taken by aspiring practitioners, but also by qualified men suffering social and occupational decline.

The most obvious omission from this list of occupational labels is 'general practitioner'. The term was in widespread use by the 1840s, and the 1881 census grouped physicians, surgeons, and general practitioners together as emphatic representatives of the 'medical profession' in its occupational tables. Even so, the phrase does not generate many hits in contemporary newspapers and journals.¹²⁴ This suggests that, even if the profession was increasingly categorising itself in terms of general practice from within, the reading public and journalists were adhering to more traditional terminology in characterising practitioners from without.

A sequence of structured searches of digitised newspapers for this delimited range of occupational descriptors permits an analysis of career disruptions of one form or another for over 1,500 practitioners across the period 1780–1890, with a clustering of cases after 1840. The information and attitudes displayed in the collective articles naming these men are rarely available from other sources, and certainly would

not be retrievable in similar numbers. The patchy survival of coroners' court records, for example, would be unlikely to yield similar returns even if all survivals were to be digitised, and the extant searchable versions of medical journals such as *The Lancet* and the *British Medical Journal* merely reveal laudatory histories of practitioners as great, or at least respectable, men. Therefore, scrutinising the incidence and reception of medical misadventure must hinge on digitised lay newspapers.

Collective biography and resisting 'great men'

This book represents the latest in a short line of medical cohort studies examining the working experiences, private lives, and deaths of practitioners.¹²⁵ Unlike these, it is not chiefly concerned with the ways that professionalisation was promoted and consolidated, but instead foregrounds the ways in which it was halted, retarded or undermined. The criteria for falling short helped to define the boundaries of acceptable behaviour and practice every bit as decisively as criteria for achievement. Furthermore, it is not dealing with a discrete group of men (such as students in Scotland, recruitment to the armed services or work-house medical officers), but with participation in certain types of event, where only some of the evidence for each event can be compiled systematically; in other cases searches might be applied logically but discoveries are more hit and miss.¹²⁶

As such it represents in part an ongoing desire, deep-rooted but a widespread and explicit objective from the 1960s, to move away from the history of medicine as the biography of great men.¹²⁷ The 'individual-and-idea, biobibliographic approach' has been stifling in two ways, because it probably conferred undue credit on some men while certainly inhibiting histories of the profession more broadly.¹²⁸ Initial attempts to move away from this model found expression in a variety of social history that brought patients to the fore, among other things by charting the fall and rise of the patient narrative. Recognition of the full potential of this trend is still being unpacked; seeing practitioners as patients, or as fallible humans who may be subject to the law rather than as expert witnesses, remains exceptional.¹²⁹ Development of the field will involve additional sceptical investigation of how doctors emerged at or near the top of the Victorian hierarchy of credibility, and how notions of exemplary lives or medical heroism were generated.¹³⁰

To undertake this work is not to attack medicine as a profession, in the way perhaps exemplified by some sociological writers of the 1960s and 1970s or periodically expressed as part of the general decline of orthodox medical authority across the second half of the twentieth century.¹³¹ The intent here is not so much to question the greatness of some individual men or to undermine medical authority further, as to address the implied applicability of greatness and power inherent in late Victorian conceptions of medical professionals. Not only is it the case that not everyone can be great, it is also evident that inadequacy can take many forms and be expressed variably over a career and life-cycle. This involves more than merely showing the weaknesses of heroes in order to magnify the achievement of their greatness, by subordinating evidence of their humanity to the larger project of lauding their ideas or scientific discoveries.¹³² Imperfection functions in multiple ways; the stress here is on a series of recorded frailties that shed direct light on turbulent careers, but that also indirectly focus attention on the way that medical status was, and is, constructed.

This is important to the ongoing historical study of the medical profession because any public stridency or power expressed by the late 1880s was matched by the continuation of private fragility, of medical authority and identity. Historians of masculinity have observed that 'the very process of acquiring social dominance may be subjectively experienced as oppression', and collectively and cumulatively this is what has happened in medicine.¹³³ Recognition of practitioners past and present as human beings first and medical practitioners second will serve to alleviate the pressures imposed by presumptions of skill and authority from both within and outside the profession. Unrealistic expectations in the twenty-first century are in part a product of nineteenth-century handling of evidence for falling short.

Notes

- 1 General Medical Council, *The Medical Register* (London: General Medical Council, 1859), p. 151; General Medical Council, *The Medical Register* (London: General Medical Council, 1863), p. 196; National Archives (N.A.) HO 107/624/4; London Metropolitan Archives P90/PAN1, Saint Pancras Parish Church register of marriages item 127, marriage of

- 18 December 1860; I am indebted to Chris Adams for additional information concerning the wider Hoyle family.
- 2 'Smallpox', *Lincolnshire Chronicle* 20 November 1863, p. 5 and 'Board of Guardians' 23 April 1864, p. 5; Lincolnshire Archives, HOSP/ST JOHNS/2/13/3 Lincolnshire Lunatic Asylum male case book G-O 1870–82, f. 440 and 440r for Hoyle's death on 14 December 1893.
 - 3 [Untitled] *London Gazette* 7 February 1862, p. 697; 'Nottingham Bankruptcy Court', *Lincolnshire Chronicle* 28 February 1862, p. 7.
 - 4 [Untitled] *Lincolnshire Chronicle* 17 October 1862, p. 5, and 'Borough Police', *ibid.* 26 November 1869, p. 7.
 - 5 Lincolnshire Archives, HOSP/ST JOHNS/2/13/3 Lincolnshire Lunatic Asylum male case book G-O 1870–82, f. 163.
 - 6 [Untitled] *Lincoln, Rutland and Stamford Mercury* 30 May 1845 p. 3, 'The Mystery', *ibid.* 6 June 1845 p. 3 and [untitled] *ibid.* 8 August 1845 p. 3.
 - 7 S.F. Simmons, *The Medical Register for the year 1779* (London: J. Murray, 1779); 49 & 50 Vict c 48.
 - 8 M.J. Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley: California University Press, 1978), p. 2.
 - 9 T.L. Alborn, 'The moral of the failed bank: professional plots in the Victorian money market', *Victorian Studies* 38:2 (1995), pp. 199–226, on p. 220; see Chapter 1 for a comparison of the numbers of late-nineteenth century medical and legal bankrupts.
 - 10 See among others the conviction for murder of Edward Pritchard in Glasgow, 1865, treated briefly in Chapter 4.
 - 11 This distinction is also necessitated by the risk that practitioners' national identity or place of origin might not be revealed alongside revelations of career turbulence; unlike with cohorts of practitioners in the Army Medical Department studied by Ackroyd et al., it is not possible to know country of birth for the majority of men discussed in these chapters. See A. Crowther and M. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007) and M. Ackroyd, L. Brockliss, M. Moss, K. Retford, and J. Stevenson, *Advancing with the Army. Medicine, the Professions and Social Mobility in the British Isles 1790–1850* (Oxford: Oxford University Press, 2006) for the centrality of Irish and Scottish practitioners to medical professionalisation.
 - 12 J. Malpas and G. Wickham, 'Governance and failure: on the limits of sociology', *Australian and New Zealand Journal of Sociology* 31:1 (1995), pp. 37–50, on p. 43.
 - 13 Professionalisation in medicine is a wide field, but see particularly M. Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c.1750–c.1850* (Manchester: Manchester University Press, 2011);

- Crowther and Dupree, *Medical Lives*; A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911* (Cambridge: Cambridge University Press, 1994); I. Loudon, *Medical Care and the General Practitioner, 1750–1850* (Oxford: Oxford University Press, 1986); H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780–1870* (Cambridge: Cambridge University Press, 1987); Peterson, *Medical Profession*.
- 14 M.J.D. Roberts, 'The politics of professionalisation: MPs, medical men, and the 1858 Medical Act', *Medical History* 53:1 (2009), pp. 37–56, on pp. 39, 44.
 - 15 Wakley was of course not the sole driver of reform, see I. Waddington, 'The development of medical ethics – a sociological analysis', *Medical History* 19:1 (1975), pp. 36–51, nor necessarily a righteous figure, see R. Porter, *Disease, Medicine and Society in England, 1550–1860* (Cambridge: Cambridge University Press, 1995), p. 48; for his dependency on radicalism of the period more broadly, see M. Brown, "Rats, bats, and barristers": *The Lancet*, libel and the radical stylistics of early nineteenth century medicine', *Social History* 39:2 (2014), pp. 182–209.
 - 16 T.A. Lee, 'The professional journal as a signal of movement to occupational ascendancy and as legitimization of a professional project: the early history of *The Accountant's Magazine* 1897–1951', *Accounting History* 11:1 (2006), pp. 7–40, on p. 10.
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 - 18 S. Lawrence, *Charitable Knowledge. Hospital Pupils and Practitioners in Eighteenth-century London* (Cambridge: Cambridge University Press, 2002), pp. 337–8; I. Loudon, 'Medical Education and Medical Reform', in V. Nutton and R. Porter (eds), *The History of Medical Education in Britain* (Amsterdam: Rodopi, 1995), pp. 229–49, on p. 231–2.
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 - 20 Brown, *Performing Medicine*, p. 226.
 - 21 P.C. Kjaergaard, 'Competing allies: professionalisation and the hierarchy of science in Victorian Britain', *Centaureus* 44 (2002), pp. 248–88, on p. 249.
 - 22 Roberts, 'Politics of professionalisation', p. 38.
 - 23 Roberts, 'Politics of professionalisation', p. 40. The informal and unwritten history of practitioners treating the poor freely was superseded in the eighteenth century by the formalised, public honorary positions that medical men took with charitable infirmaries and dispensaries; M. Brown, 'From the Doctors' Club to the Medical Society: Medicine, Gentility, and

- Social Space in York, 1780–1840’ in M. Hallett and J. Rendell (eds), *Eighteenth-Century York: Culture, Space and Society* (York: Borthwick Society, 2003), pp. 59–69, on p. 63.
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 - 25 H. MacDonald, ‘Procuring corpses: the English anatomy inspectorate 1842–1858’, *Medical History* 53:3 (2009), pp. 379–96, on p. 388.
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 - 27 Inkster, ‘Marginal Men’, p. 128; Brown, *Performing Medicine*.
 - 28 J.P. Eigen, ‘“I answer as a Physician”: Opinion as Fact in pre-McNaughtan Insanity Trials’, in M. Clark and C. Crawford (eds), *Legal Medicine in History* (Cambridge: Cambridge University Press, 1994), pp. 167–99.
 - 29 Roberts, ‘Politics of professionalisation’, pp. 53–5.
 - 30 Inkster, ‘Marginal Men’, p. 152.
 - 31 The historiography of the concept is summarised in M.S.R. Jenner and P. Wallis, ‘Introduction’, in M.S.R. Jenner and P. Wallis (eds), *Medicine and the Market in England and its Colonies, c.1450–c.1850* (Basingstoke: Palgrave Macmillan, 2007), pp. 1–23.
 - 32 Digby, *Making a Medical Living*, chapter five.
 - 33 M. Fissell, ‘Innocent and Honourable Bribes: Medical Manners in Eighteenth-century Britain’, in R. Baker, D. Porter, and R. Porter (eds), *The Codification of Medical Morality Volume One: Medical Ethics and Etiquette in the Eighteenth Century* (Dordrecht: Kluwer Academic Publishers, 1993), pp. 19–45, on pp. 38–9.
 - 34 Brown, *Performing Medicine*.
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 - 36 See, for example, an early reference in T. Percival, *Medical Ethics* (Manchester: S. Russell, 1803), p. 47 and later discussions in, *inter alia*, the *British Medical Journal* in 1864 on the wisdom or otherwise of tendering gratuitous medical services.
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 - 39 Quote from C. Stebbings, ‘Tax and Pharmacy: A Synergy in Professional Evolution’, in P. Harris and D. De Cogan, *Studies in the History of Tax Law* 7 (2015), pp. 153–69, on p. 163.

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- 43 'Courts medical', *The Lancet* 48:1203 (1846), p. 334.
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- 45 Andrew Carrick in 1833, quoted in W.H. McMenemy, *The Life and Times of Sir Charles Hastings, Founder of the British Medical Association* (Edinburgh: Livingstone, 1959), p. 99.
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- 47 Peterson, *Medical Profession*, p. 252.
- 48 J. Tosh, 'Gentlemanly politeness and manly simplicity in Victorian England', *Transactions of the Royal Historical Society* 12 (2002), pp. 455–72, on p. 467.
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- 50 Brown, 'Doctors' club', p. 63; Ford, 'John Gorham', pp. 37–8 for an instance of financial manipulation for personal gain.
- 51 Percival, *Medical Ethics*.
- 52 Waddington, 'Development of medical ethics'.
- 53 A-H. Maehle, 'Medical Ethics and the Law', in M. Jackson (ed.), *The Oxford Handbook of the History of Medicine* (Oxford: Oxford University Press, 2011), pp. 543–60, on p. 545.
- 54 Burnham, *How the Idea*, p. 65.
- 55 Crowther and Dupree, *Medical Lives*, p. 2.
- 56 C. Brock, 'The *Lancet* and the Campaign against Women Doctors, 1860–1880', in A.M. Caleb (ed.) *(Re)Creating Science in Nineteenth-Century Britain* (Newcastle: Cambridge Scholars Publishing, 2007), pp. 130–45.
- 57 Brock, 'The *Lancet*', p. 132.
- 58 See Peterson, *Medical Profession*, chapter 2 for practitioners' collective identity as students plus their pride and loyalty in professional affiliations,

- endorsed by Rosner's conclusions of education conferring medical unity; see L. Rosner, *Medical Education in the Age of Improvement. Edinburgh Students and Apprentices 1760–1826* (Edinburgh: Edinburgh University Press, 1991). Sophia Jex-Blake denigrated the behaviour of her fellow (male) medical students as unworthy of 'a body of men claiming the name of gentlemen'; quoted in Brock, 'The *Lancet*', p. 140.
- 59 Peterson, *Medical Profession*, p. 131 quoting Dr Isaac Ashe in the Carmichael Prize essay of 1868.
 - 60 J. Rogers, *Reminiscences of a Workhouse Medical Officer* (London: T. Fisher Unwin, 1889); preface by Professor Thorold Rogers, p. vii.
 - 61 Peterson, *Medical Profession*, pp. 132, 196.
 - 62 J.R. Walkowitz, *Prostitution and Victorian Society. Women, Class and the State* (Cambridge: Cambridge University Press, 1990), pp. 108–9.
 - 63 F.P. Cobbe, 'The medical profession and its morality', *Modern Review* 2 (1881), pp. 7–42.
 - 64 Peterson, *Medical Profession*, p. 226 and *passim* has discussed evidence of protectionism and failures of intra-professional co-operation at the macro level of the Royal Colleges. This book is concerned rather with the deleterious effects of competitive behaviour at the individual and personal level.
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 - 66 Tosh, 'Gentlemanly politeness'.
 - 67 J. Tosh, *A Man's Place. Masculinity and the Middle-Class Home in Victorian England* (New Haven: Yale University Press, 1999), pp. 1–2.
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 - 71 R.B. Baker, 'The Discourses of Practitioners in 19th- and 20th-Century Britain and the United States', in R.B. Baker and L.B. McCullough (eds), *The Cambridge World History of Medical Ethics* (Cambridge: Cambridge University Press, 2009), pp. 446–64, on p. 450.
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- 82 Alborn, 'The moral of the failed bank', p. 222.
- 83 See Chapter 5 for the cases of Angus Cameron and William Gibson; A.E. Tomkins, 'Casenotes and Madness', in M. Jackson (ed.), *The Routledge History of Disease* (London: Routledge, 2016) for the case of Charles Beard.
- 84 Anxiety was the characteristic identified by Fildes' son and biographer; L.V. Fildes, *Luke Fildes RA, A Victorian Painter* (London: Michael Joseph, 1968), p. 114. The print was one of the most successful ever printed by Agnews; www.tate.org.uk/art/artworks/fildes-the-doctor-n01522/text-summary viewed 15 January 2015.
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- 86 J. Atkinson, *Victorian Biography Reconsidered. A Study of Nineteenth-century 'Hidden' Lives* (Oxford: Oxford University Press, 2010), p. 112.
- 87 D.M. Evans, *Facts, Failures, and Frauds: Revelations Financial Mercantile Criminal* (Groombridge: London, 1859); Alborn, 'The moral of the failed bank'.

- 88 Practitioners' physical inadequacies raised comment among campaigners for female medical training such as Emily Davis; Brock, 'The *Lancet*', p. 133. See Chapters 5 and 6 for fuller treatment of practitioners' mental fragility.
- 89 J. Ruskin, 'The Nature of Gothic', in D. Birch (ed.), *John Ruskin: Selected Writings* (Oxford: Oxford University Press, 2004), pp. 32–63, on p. 39.
- 90 J. Richards, 'Passing the Love of Women: Manly Love and Victorian Society', in J.A. Mangan and J. Walvin (eds), *Manliness and Morality. Middle-class Masculinity in Britain and America 1800–1940* (Manchester: Manchester University Press, 1987), pp. 92–122, on p. 105.
- 91 Atkinson, *Victorian Biography*, p. 114.
- 92 See, for example, the posthumous readmission of Francis Fox to the medical fold in Derby, outlined in Chapter 5, following his support for working-class causes and alleged mental instability.
- 93 Peterson, *Medical Profession*, p. 126. This book alludes to a bi-partite profession, distinguishing between the successes of the London medical elite and the struggles of the overcrowded rank-and-file, p. 246.
- 94 Loudon, *Medical Care*, pp. 256–66.
- 95 See, for example, Digby, *Evolution*, pp. 281–2 for a rapid treatment of professional stress, propensity to suicide, alcohol or drug addiction, and sexual misconduct.
- 96 Brown, 'Doctors' club' p. 63; the stresses of the medical marketplace in the nineteenth century are given only generalised treatment in his book, see Brown, *Performing Medicine*, p. 115.
- 97 Smith, *Medical Discipline*, pp. 99, 238–45. It is also a poor guide to erasures from the *Register*, as only 31 percent of cases generated this result.
- 98 Smith, *Medical Discipline*, p. 99.
- 99 Smith, *Medical Discipline*, p. 100.
- 100 Smith, *Medical Discipline*, p. 200. Only 6 percent of cases lead to re-registration up to 1890, pp. 238–45.
- 101 C. Kelly, *War and the Militarization of British Army Medicine, 1793–1830* (London: Pickering and Chatto, 2011), pp. 4–5.
- 102 Ackroyd et al., *Advancing with the Army*; M.J. Cardwell, 'Royal Navy Surgeons, 1793–1815: A Collective Biography', in D.B. Haycock and S. Archer (eds), *Health and Medicine at Sea 1700–1900* (Woodbridge: Boydell Press, 2009), pp. 38–62.
- 103 Price, *Medical Negligence*.
- 104 B. Milligan, 'Morphine-addicted doctors, the English opium eater, and embattled medical authority', *Victorian Literature and Culture* 33 (2005), pp. 541–53.

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- 106 The same exceptionalism has been used to illustrate related developments, such as the evolution of responses to murder, to press reporting, or to the conduct of coroners' courts; see J. Flanders, *The Invention of Murder: How the Victorians Revelled in Death and Detection and Created Modern Crime* (London: Harper Press, 2011); Burney, *Poison*.
- 107 A.E. Tomkins, 'Mad doctors?: The significance of medical practitioners admitted as patients to the first English county asylums up to 1890', *History of Psychiatry* 23:4 (2012), pp. 437–53; Tomkins, 'Casenotes'.
- 108 Sullivan, 'Spectacular failures', p. 85.
- 109 Sullivan, 'Spectacular failures', p. 85.
- 110 K.O. Garrigan, 'Foreword: Decorum, Scandal, and the Press', in K.O. Garrigan (ed.), *Victorian Scandals. Representations of Gender and Class* (Athens: Ohio University Press, 1992), pp. 1–8, on p. 5.
- 111 A. Bingham, 'Reading newspapers: cultural histories of the popular press in modern Britain', *History Compass* 10:2 (2012), pp. 140–50, on p. 142.
- 112 Bingham, 'Reading newspapers', p. 144.
- 113 A. Bingham, 'The digitization of newspaper archives: opportunities and challenges for historians', *Twentieth Century British History* 21:2 (2010), pp. 225–31, on p. 228.
- 114 British Library Newspapers, find.galegroup.com/bncn/, accessed from 1 May 2005 onwards. The database is used particularly heavily in Chapters 3, 4 and 6. Chapter 1 also uses the digitised *London Gazette* to identify bankruptcies and insolvencies.
- 115 The editorial complexion of some newspapers and the impact of policy upon reporting of medical issues are discussed at more length in relevant chapters, particularly Chapter 6.
- 116 A. Hobbs, 'The deleterious dominance of *The Times* in nineteenth-century scholarship', *Journal of Victorian Culture* 18:4 (2013), pp. 472–97, on pp. 472, 479; *The Times* would also have been a poor choice given its relative sparsity of non-political news, pp. 481, 484.
- 117 Nicholson, 'Counting Culture', p. 242.
- 118 J. Shaw, 'Selection of newspapers', *British Library Newspapers* (Detroit: Gale Cengage Learning, 2007); http://find.galegroup.com/bncn/page.do?page=/bncn_about.jsp&prodId=BNCN&userGroupName=kele_tr viewed 11 November 2014 specifies forty-eight titles, but the website's own title list gives forty-nine titles for part I of the database. The title list also supplies the number of periodicals chosen for parts II, III, and IV of the project.

- 119 A. Prescott, 'I'd rather be a librarian. A response to Tim Hitchcock, "Confronting the Digital"', *Cultural and Social History* 11:3 (2014), pp. 335–41, on p. 340.
- 120 N.A. HO 107/808/42.
- 121 Worcestershire Record Office, B/A 10371 Ref 499:9, parcel 4: Powick Hospital patients' case book volume 9 1863–72, patient number 1339.
- 122 St Andrew's Healthcare archive, CL4 St Andrew's asylum case notes from 1863, p. 401.
- 123 N.A. RG 10/1200/13.
- 124 P.J. Corfield, *Power and the Professions in Britain 1700–1850* (London: Routledge, 1995), p. 149 observes that in the early nineteenth century the composite noun first acquired currency within the medical community. The British Library Newspapers database displayed 2,312 hits for the phrase 'general practitioner' but 1,008,962 hits for 'surgeon' on 15 January 2015; very few of the hits for general practitioner were substantive for the proximity searches conducted here.
- 125 Brown, *Performing Medicine*; Ackroyd et al., *Advancing with the Army*; Crowther and Dupree, *Medical Lives*; Cardwell, 'Royal Navy Surgeons'.
- 126 Price *Medical Negligence*, which treats workhouse medical officers, is the only other historical work to consider medical career turbulence at length.
- 127 Narrow biographical histories were attacked by writers in the field from the first decade of the twentieth century, but the reach and impact of the attacks was only effective much later; Burnham, *How the Idea*, pp. 42, 113–14.
- 128 Burnham, *How the Idea*, p. 46 and *passim*.
- 129 A. Gawande, 'Why Do Doctors Fail?' (Reith lecture 25 November 2014); H. Marsh, *Do No Harm: Stories of Life, Death, and Brain Surgery* (London: Weidenfeld and Nicolson, 2014); Tomkins, 'Casenotes'.
- 130 S. Nenadic, 'Portraits of Scottish professional men in London, c. 1760–1830', *Journal for Eighteenth-Century Studies* 34:1 (2011), pp. 1–17; M. Brown, "'Like a Devoted Army": medicine, heroic masculinity, and the military paradigm in Victorian Britain', *Journal of British Studies* 49:3 (2010), pp. 592–622.
- 131 Burnham, *How the Idea*, pp. 112–14.
- 132 G. Sarton, *The Study of the History of Mathematics and the Study of the History of Science* (New York: Dover, 1957) quoted in T. Soderqvist, "'No genre of History fell under more odium than that of biography": the delicate relations between scientific biography and the historiography of science', in T. Soderqvist (ed.), *The History and Poetics of Scientific Biography* (Aldershot: Ashgate, 2007), pp. 241–62, on pp. 249–50.
- 133 Roper and Tosh, 'Introduction', p. 15.