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. . . Medicine has not always been the powerful, prestigious, successful, lucrative, and dominant profession we know today. The status of the medical profession is a product of medical politicking as well as therapeutic expertise. This discussion presents a brief overview of the development of the medical profession and its rise to dominance.

EMERGENCE OF THE MEDICAL PROFESSION: UP TO 1850

In ancient societies, disease was given supernatural explanations, and "medicine" was the province of priests or shamans. It was in classical Greece that medicine began to emerge as a separate occupation and develop its own theories, distinct from philosophy or theology. Hippocrates, the great Greek physician who refused to accept supernatural explanations or treatments for disease, developed a theory of the "natural" causes of disease and systematized all available medical knowledge. He laid a basis for the development of medicine as a separate body of knowledge. Early Christianity depicted sickness as punishment for sin, engendering new theological explanations and treatments. Christ and his disciples believed in the supernatural causes and cures of disease. This view became institutionalized in the Middle Ages, when the Church dogma dominated theories and practice of medicine and priests were physicians. The Renaissance in Europe brought a renewed interest in ancient Greek medical knowledge. This marked the beginning of a drift toward natural explanations of disease and the emergence of medicine as an occupation separate from the Church (Cartwright, 1977).

But European medicine developed slowly. The "humoral theory" of disease developed by Hippocrates dominated medical theory and practice

until well into the 19th century. Medical diagnosis was impressionistic and often inaccurate, depicting conditions in such general terms as "fevers" and "fluxes." In the 17th century, physicians relied mainly on three techniques to determine the nature of illness: what the patient said about symptoms; the physician's own observations of signs of illness and the patient's appearance and behavior; and more rarely, a manual examination of the body (Reiser, 1978, p. 1). Medicine was by no means scientific, and "medical thought involved unverified doctrines and resulting controversies" (Shryock, 1960, p. 52). Medical practice was a "bedside medicine" that was patient oriented and did not distinguish the illness from the "sick man" (Jewson, 1976). It was not until Thomas Sydenham's astute observations in the late 17th century that physicians could begin to distinguish between the patient and the disease. Physicians possessed few treatments that worked regularly, and many of their treatments actually worsened the sufferer's condition. Medicine in colonial America inherited this European stock of medical knowledge.

Colonial American medicine was less developed than its European counterpart. There were no medical schools and few physicians, and because of the vast frontier and sparse population, much medical care was in effect self-help. Most American physicians were educated and trained by apprenticeship; few were university trained. With the exception of surgeons, most were undifferentiated practitioners. Medical practices were limited. Prior to the revolution, physicians did not commonly attend births; midwives, who were not seen as part of the medical establishment, routinely attended birthings (Wertz and Wertz, 1977). William Rothstein (1972) notes that "American colonial medical practice, like European practice of the period, was characterized by the lack of any substantial body of usable scientific knowledge" (p. 27). Physicians,

both educated and otherwise, tended to treat their patients pragmatically, for medical theory had little to offer. Most colonial physicians practiced medicine only part-time, earning their livelihoods as clergymen, teachers, farmers, or in other occupations. Only in the early 19th century did medicine become a full-time vocation (Rothstein, 1972).

The first half of the 19th century saw important changes in the organization of the medical profession. About 1800, "regular," or educated, physicians convinced state legislatures to pass laws limiting the practice of medicine to practitioners of a certain training and class (prior to this nearly anyone could claim the title "doctor" and practice medicine). These state licensing laws were not particularly effective, largely because of the colonial tradition of medical self-help. They were repealed in most states during the Jacksonian period (1828-1836) because they were thought to be elitist, and the temper of the times called for a more "democratic" medicine.

The repeal of the licensing laws and the fact that most "regular" (i.e., regularly educated) physicians shared and used "a distinctive set of medically invalid therapies, known as 'heroic' therapy," created fertile conditions for the emergence of *medical sects* in the first half of the 19th century (Rothstein, 1972, p. 21). Physicians of the time practiced a "heroic" and invasive form of medicine consisting primarily of such treatments as bloodletting, vomiting, blistering, and purging. This highly interventionist, and sometimes dangerous, form of medicine engendered considerable public opposition and resistance. In this context a number of medical sects emerged, the most important of which were the homeopathic and botanical physicians. These "irregular" medical practitioners practiced less invasive, less dangerous forms of medicine. They each developed a considerable following, since their therapies were probably no less effective than those of regulars practicing heroic medicine. The regulars attempted to exclude them from practice; so the various sects set up their own medical schools and professional societies. This sectarian medicine created a highly *competitive* situation for the regulars (Rothstein, 1972). Medical sectarianism, heroic therapies, and ineffective treatment contributed to the low status

and lack of prestige of early 19th-century medicine. At this time, medicine was neither a prestigious occupation nor an important economic activity in American society (Starr, 1977).

The regular physicians were concerned about this situation. Large numbers of regularly trained physicians sought to earn a livelihood by practicing medicine (Rothstein, 1972, p. 3). They were troubled by the poor image of medicine and lack of standards in medical training and practice. No doubt they were also concerned about the competition of the irregular sectarian physicians. A group of regular physicians founded the American Medical Association (AMA) in 1847 "to promote the science and art of medicine and the betterment of public health" (quoted in Coe, 1978, p. 204). The AMA also was to set and enforce standards and ethics of "regular" medical practice and strive for exclusive professional and economic rights to the medical turf.

The AMA was the crux of the regulars' attempt to "professionalize" medicine. As Magali Sarfatti Larson (1977) points out, professions organize to create and control *markets*. Organized professions attempt to regulate and limit the competition, usually by controlling professional education and by limiting licensing. Professionalization is, in this view, "the process by which producers of special services sought to constitute and control the market for their expertise" (Larson, 1977, p. xvi). The regular physicians and the AMA set out to consolidate and control the market for medical services. As we shall see in the next two sections, the regulars were successful in professionalization, eliminating competition and creating a medical monopoly.

CRUSADING, DEVIANCE, AND MEDICAL MONOPOLY: THE CASE OF ABORTION

The medical profession after the middle of the 19th century was frequently involved in various activities that could be termed social reform. Some of these reforms were directly related to health and illness and medical work; others were peripheral to the manifest medical calling of preventing illness and healing the sick. In these re-

form movements, physicians became medical crusaders, attempting to influence public morality and behavior. This medical crusading often led physicians squarely into the moral sphere, making them advocates for moral positions that had only peripheral relations to medical practice. Not infrequently these reformers sought to change people's values or to impose a set of particular values on others. . . . We now examine one of the more revealing examples of medical crusading: the criminalization of abortion in American society.¹

Most people are under the impression that abortion was always defined as deviant and illegal in America prior to the Supreme Court's landmark decision in 1973. This, however, is not the case. American abortion policy, and the attendant defining of abortion as deviant, were specific products of medical crusading. Prior to the Civil War, abortion was a common and largely legal medical procedure performed by various types of physicians and midwives. A pregnancy was not considered confirmed until the occurrence of a phenomenon called "quickeening," the first perception of fetal movement. Common law did not recognize the fetus before quickening in criminal cases, and an unquickenéd fetus was deemed to have no living soul. Thus most people did not consider termination of pregnancy before quickening to be an especially serious matter, much less murder. Abortion before quickening created no moral or medical problems. Public opinion was indifferent, and for the time it was probably a relatively safe medical procedure. Thus, for all intents and purposes, American women were free to terminate their pregnancies before quickening in the early 19th century. Moreover, it was a procedure relatively free of the moral stigma that was attached to abortion in this century.

After 1840 abortion came increasingly into public view. Abortion clinics were vigorously and openly advertised in newspapers and magazines. The advertisements offered euphemistically couched services for "women's complaints," "menstrual blockage," and "obstructed menses." Most contemporary observers suggested that more and more women were using these services. Prior to 1840 most abortions were performed on the unmarried and

desperate of the "poor and unfortunate classes." However, beginning about this time, significantly increasing numbers of middle- and upper-class white, Protestant, native-born women began to use these services. It is likely they either wished to delay childbearing or thought they already had all the children they wanted (Mohr, 1978, pp. 46-47). By 1870 approximately one abortion was performed for every five live births (Mohr, 1978, pp. 79-80).

Beginning in the 1850s, a number of physicians, especially moral crusader Dr. Horatio Robinson Storer, began writing in medical and popular journals and lobbying in state legislatures about the danger and immorality of abortion. They opposed abortion before and after quickening and under Dr. Storer's leadership organized an aggressive national campaign. In 1859 these crusaders convinced the AMA to pass a resolution condemning abortion. Some newspapers, particularly *The New York Times*, joined the antiabortion crusade. Feminists supported the crusade, since they saw abortion as a threat to women's health and part of the oppression of women. Religious leaders, however, by and large avoided the issue of abortion, either they didn't consider it in their province or found it too sticky an issue to discuss. It was the physicians who were the guiding force in the antiabortion crusade. They were instrumental in convincing legislatures to pass state laws, especially between 1866 and 1877, that made abortion a criminal offense.

Why did physicians take the lead in the antiabortion crusade and work so directly to have abortion defined as deviant and illegal? Undoubtedly they believed in the moral "rightness" of their cause. But social historian James Mohr (1978) presents two more subtle and important reasons for the physicians' antiabortion crusading. First, concern was growing among medical people and even among some legislators about the significant drop in birthrates. Many claimed that abortion among married women of the "better classes" was a major contributor to the declining birthrate. These middle- and upper-class men (the physicians and legislators) were aware of the waves of immigrants arriving with large families and were anxious about the decline in production of native American babies.

They were deeply afraid they were being betrayed by their own women (Mohr, 1978, p. 169). Implicitly the antiabortion stance was classist and racist; the anxiety was simply that there would not be enough strong, native-born, Protestant stock to save America. This was a persuasive argument in convincing legislators of the need of antiabortion laws.

The second and more direct reason spurring the physicians in the antiabortion crusade was to aid their own nascent professionalization and create a monopoly for regular physicians. . . . The regulars had formed the AMA in 1847 to promote scientific and ethical medicine and combat what they saw as medical quackery. There were, however, no licensing laws to speak of, and many claimed the title "doctor" (e.g., homeopaths, botanical doctors, eclectic physicians). The regular physicians adopted the Hippocratic oath and code of ethics as their standard. Among other things, this oath forbids abortion. Regulars usually did not perform abortions; however, many practitioners of medical sects performed abortions regularly, and some had lucrative practices. Thus for the regular AMA physicians the limitation of abortion became one way of asserting their own professional domination over other medical practitioners. In their crusading these physicians had translated the social goals of cultural and professional dominance into moral and medical language. They lobbied long and hard to convince legislators of the danger and immorality of abortion. By passage of laws making abortion criminal any time during gestation, regular physicians were able to legislate their code of ethics and get the state to employ sanctions against their competitors. This limited these competitors' markets and was a major step toward the regulars' achieving a monopolization of medical practice.

In a relatively short period the antiabortion crusade succeeded in passing legislation that made abortion criminal in every state. A by-product of this was a shift in American public opinion from an indifference to and tolerance of abortion to a hardening of attitudes against what had until then been a fairly common practice. The irony was that abortion as a medical procedure probably was safer at the turn of the 20th century than a century before, but it was

defined and seen as more dangerous. By 1900 abortion was not only illegal but deviant and immoral. The physicians' moral crusade had successfully defined abortion as a deviant activity. This definition remained largely unchanged until the 1973 Supreme Court decision, which essentially returned the abortion situation to its pre-1850 condition. . . .

GROWTH OF MEDICAL EXPERTISE AND PROFESSIONAL DOMINANCE

Although the general public's dissatisfaction with heroic medicine remained, the image of medicine and what it could accomplish was improving by the middle of the 19th century. There had been a considerable reduction in the incidence and mortality of certain dread diseases. The plague and leprosy had nearly disappeared. Smallpox, malaria, and cholera were less devastating than ever before. These improvements in health engendered optimism and increased people's faith in medical practice. Yet these dramatic "conquests of disease" were by and large *not* the result of new medical knowledge or improved clinical medical practice. Rather, they resulted from changes in social conditions: a rising standard of living, better nutrition and housing, and public health innovations like sanitation. With the lone exception of vaccination for smallpox, the decline of these diseases had nearly nothing to do with clinical medicine (Dubos, 1959; McKeown, 1971). But despite lack of effective treatments, medicine was the beneficiary of much popular credit for improved health.

The regular physicians' image was improved well before they demonstrated any unique effectiveness of practice. The AMA's attacks on irregular medical practice continued. In the 1870s the regulars convinced legislatures to outlaw abortion and in some states to restore licensing laws to restrict medical practice. The AMA was becoming an increasingly powerful and authoritative voice representing regular medical practice.

But the last three decades of the century saw significant "breakthroughs" in medical knowledge and treatment. The scientific medicine of the regular physicians was making new medical advances. Anesthesia and antisepsis made possi-

ble great strides in surgical medicine and improvements in hospital care. The bacteriological research of Koch and Pasteur developed the "germ theory of disease," which had important applications in medical practice. It was the accomplishments of surgery and bacteriology that put medicine on a scientific basis (Freidson, 1970a, p. 16). The rise of scientific medicine marked a death knell for medical sectarianism (e.g., the homeopathic physicians eventually joined the regulars). The new laboratory sciences provided a way of testing the theories and practices of various sects, which ultimately led to a single model of medical practice. The well-organized regulars were able to legitimate their form of medical practice and support it with "scientific" evidence.

With the emergence of scientific medicine, a unified paradigm, or model, of medical practice developed. It was based, most fundamentally, on viewing the body as a machine (e.g., organ malfunctioning) and on the germ theory of disease (Kelman, 1977). The "doctrine of specific etiology" became predominant: each disease was caused by a specific germ or agent. Medicine focused solely on the internal environment (the body), largely ignoring the external environment (society) (Dubos, 1959). This paradigm proved fruitful in ensuing years. It is the essence of the "medical model." . . .

The development of scientific medicine accorded regular medicine a convincing advantage in medical practice. It set the stage for the achievement of a medical monopoly by the AMA regulars. As Larson (1977) notes, "Once scientific medicine offered sufficient guarantees of its superior effectiveness in dealing with disease, the rate willingly contributed to the creation of a monopoly by means of registration and licensing" (p. 23). The new licensing laws created regular medicine as a *legally enforced monopoly of practice* (Freidson, 1970b, p. 83). They virtually eliminated medical competition.

The medical monopoly was enhanced further by the Flexner Report on medical education in 1910. Under the auspices of the Carnegie Foundation, medical educator Abraham Flexner visited nearly all 160 existing medical schools in the United States. He found the level of medical education poor and recommended the closing of

most schools. Flexner urged stricter state laws, rigid standards for medical education, and more rigorous examinations for certification to practice. The enactment of Flexner's recommendations effectively made all nonscientific types of medicine illegal. It created a near total AMA monopoly of medical education in America.

In securing a monopoly, the AMA regulars achieved a unique professional state. Medicine not only monopolized the market for medical services and the training of physicians, it developed an unparalleled "professional dominance." The medical profession was *functionally autonomous* (Freidson, 1970b). Physicians were insulated from external evaluation and were by and large free to regulate their own performance. Medicine could define its own territory and set its own standards. Thus, Eliot Freidson (1970b) notes, "while the profession may not everywhere be free to control the *terms* of its work, it is free to control the *content* of its work" (p. 84).

The domain of medicine has expanded in the past century. This is due partially to the prestige medicine has accrued and its place as the steward of the "sacred" value of life. Medicine has sometimes been called on to repeat its "miracles" and successful treatments on problems that are not biomedical in nature. Yet in other instances the expansion is due to explicit medical crusading or entrepreneurship. This expansion of medicine, especially into the realm of social problems and human behavior, frequently has taken medicine beyond its proven technical competence (Freidson, 1970b). . . .

The organization of medicine has also expanded and become more complex in this century. In the next section we briefly describe the structure of medical practice in the United States.

STRUCTURE OF MEDICAL PRACTICE

Before we leave our discussion of the medical profession, it is worthwhile to outline some general features of the structure of medical practice that have contributed to the expansion of medical jurisdiction.

The medical sector of society has grown enormously in the 20th century. It has become the

second largest industry in America. There are about 350,000 physicians and over 5 million people employed in the medical field. The "medical industries," including the pharmaceutical, medical technology, and health insurance industries, are among the most profitable in our economy. Yearly drug sales alone are over \$4.5 billion. There are more than 7000 hospitals in the United States with 1.5 million beds and 33 million inpatient and 200 million outpatient visits a year (McKinlay, 1976).

The organization of medical practice has changed. Whereas the single physician in "solo practice" was typical in 1900, today physicians are engaged increasingly in large corporate practices or employed by hospitals or other bureaucratic organizations. Medicine in modern society is becoming bureaucratized (Mechanic, 1976). The power in medicine has become diffused, especially since World War II, from the AMA, which represented the individual physician, to include the organizations that represent bureaucratic medicine: the health insurance industry, the medical schools, and the American Hospital Association (Ehrenreich and Ehrenreich, 1970). Using Robert Alford's (1972) conceptualizations, corporate rationalizers have taken much of the power in medicine from the professional monopolists.

Medicine has become both more specialized and more dependent on technology. In 1929 only 25 percent of American physicians were fulltime specialists; by 1969 the proportion had grown to 75 percent (Reiser, 1978). Great advances were made in medicine, and many were directly related to technology: miracle medicines like penicillin, a myriad of psychoactive drugs, heart and brain surgery, the electrocardiograph, CAT scanners, fetal monitors, kidney dialysis machines, artificial organs, and transplant surgery, to name but a few. The hospital has become the primary medical workshop, a center for technological medicine.

Medicine has made a significant economic expansion. In 1940, medicine claimed about 4 percent of the American gross national product (GNP); today it claims about 9 percent, which amounts to more than \$150 billion. The causes for this growth are too complex to describe here, but a few factors should be noted. American

medicine has always operated on a "fee-for-service" basis, that is, each service rendered is charged and paid for separately. Simply put, in a capitalist medical system, the more services provided, the more fees collected. This not only creates an incentive to provide more services but also to expand these medical services to new markets. The fee-for-service system may encourage unnecessary medical care. There is some evidence, for example, that American medicine performs a considerable amount of "excess" surgery (McCleery and Keelty, 1971); this may also be true for other services. Medicine is one of the few occupations that can create its own demand. Patients may come to physicians, but physicians tell them what procedures they need. The availability of medical technique may also create a demand for itself.

The method by which medical care is paid for has changed greatly in the past half-century. In 1920 nearly all health care was paid for directly by the patient-consumer. Since the 1930s an increasing amount of medical care has been paid for through "third-party" payments, mainly through health insurance and the government. About 75 percent of the American population is covered by some form of medical insurance (often only for hospital care). Since 1966 the government has been involved directly in financing medical care through Medicare and Medicaid. The availability of a large amount of federal money, with nearly no cost controls or regulation of medical practice, has been a major factor fueling our current medical "cost crisis." But the ascendancy of third-party payments has affected the expansion of medicine in another way: more and more human problems become defined as "medical problems" (sickness) because that is the only way insurance programs will "cover" the costs of services. . . .

In sum, the regular physicians developed control of medical practice and a professional dominance with nearly total functional autonomy. Through professionalization and persuasion concerning the superiority of their form of medicine, the medical profession (represented by the AMA) achieved a legally supported monopoly of practice. In short, it cornered the medical market. The medical profession has succeeded in both therapeutic and economic expansion. It has

won the almost exclusive right to reign over the kingdom of health and illness, no matter where it may extend.

NOTE

1. We rely on James C. Mohr's (1978) fine historical account of the origins and evolution of American abortion policy for data and much of the interpretation in this section.

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