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Creating a National Medical Field: The Associated Apothecaries and Surgeon-Apothecaries, The Provincial Medical and Surgical Association, and the First Professional Project

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#### **Publication Date**

2001-05-04

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**DRAFT**

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4 May 2001

Sociologists have devoted considerable effort to understanding professional projects: how would-be professional occupations achieve collective social mobility and control over their markets. Dominant theoretical accounts treat would-be professions as unitary actors struggling against the larger world (Johnson 1972; Larson 1977; Macdonald 1995). But on the ground, incipient professions can be conflict-ridden, factionalized, politically charged collections of individuals who may not even share a common occupational identity, let alone a common set of professional goals (Starr 1982; Halliday 1987; Abbott 1988). Understanding collective mobility thus requires an explanation of where professional projects come from: how a mass of individuals with a variety of interests manages to organize itself into a group coherent enough to undertake such a project.

Furthermore, even some of the most successful professional projects, those of American law and medicine, were preceded by failed attempts at professionalization (Halliday 1987, pp. 60-63; Starr 1982, pp. 30-59). No theory yet accounts for what makes some groups within an occupation more successful than others at achieving collective mobility. Abbott (1988) comes closest to an answer with his theory of an interprofessional system of work jurisdiction, but as he admits, he “underemphasize[s] the problems of coalescence and ‘groupness’” (p. 317). My account is compatible with Abbott’s, but focuses on the fact that professional projects are also political projects, that they emerge from particular structural locations within an occupation, and that understanding which ones succeed requires we pay attention to the dynamics within as well as among occupational fields.

I propose borrowing another theoretical framework to help fill these gaps. Theories of institutions have provided tools for explaining institutional stability and change (Bourdieu 1977; Bourdieu and Wacquant 1992; Meyer and Rowan 1977; Powell and DiMaggio 1991). These tools, which have been used in a variety of empirical contexts (e.g. Fligstein 1990; Steinmo, Thelen and Longstreth 1992;

Clemens 1993; Ray 1999), focus not only on the political dynamics among collective actors that contribute to the emergence of new institutional arrangements, but also on the ways in which institutional entrepreneurs engage in skilled action to get and keep individual actors mobilized (DiMaggio 1989; Fligstein 2001). Understanding professionalization attempts as projects of institutional transformation, in which certain actors try to transform the rules which govern an occupational field, can give us analytical leverage on these questions.

This paper will analyze the prototypical case of professionalization: that of English medicine. Between roughly 1793 and 1858 the field of English medicine underwent a major transformation in which the tripartite division of labor among physicians, surgeons, and apothecaries which had organized the field for several hundred years collapsed. By the time a new structure was built, the men who once would have been called apothecaries and had the status of skilled craftsmen had become general practitioners and were well on their way to claiming the characteristics that we now see as professional: an abstract body of knowledge, occupational closure, control over education, a system of self-regulation, and a government-sanctioned monopoly over their market.

This case is interesting for two reasons. First, it is one of the first successful professional projects and as such, served as a model for later groups with professional goals (Larson 1977, pp. 154-55; Abbott 1988, p. 193; Starr 1982, chs. 1-3). The methods English doctors pioneered and the strategies they created would be borrowed again and again by other groups seeking the security and status of professionalism. Their early success set the benchmark for other occupations and, in a sense, created the concept of professionalization: that a particular set of tactics could be used to effectively achieve collective social mobility.

Second, it is an excellent case through which to explore the conditions under which professionalization attempts fail and succeed. English doctors' eventual success clearly shows us that these were conditions in which professionalization was possible. Yet a number of different organizations attempted to mobilize practitioners, reform the occupation, and achieve professional goals over a fifty-year period before one group finally managed to unite a large enough fraction of practitioners that the political agenda of professionalization could be attained.

I focus on a comparison of two of these organizations. The Associated Apothecaries and Surgeon-Apothecaries (AASA) organized a sizeable fraction of practitioners and achieved some legislative success, but did not manage to transform its early achievements into a position as representative of an emerging profession. The Provincial Medical and Surgical Association (PMSA) had only moderate political impact in its early years but eventually united the profession and, after changing its name to the British Medical Association, became the primary organizational representative of practitioners, a position it holds to the present day. I will compare the experiences of these organizations in order to understand how a professional project was first put together and what conditions contributed to success or failure.

### **Institutional Transformation and Professionalization**

Over the past twenty-five years, the study of institutions has once again come to the forefront of sociology and political science (for reviews see Jepperson forthcoming; Ingram and Clay 2000; Clemens and Cook 1999; Immergut 1998; Hall and Taylor 1996). Early work focused on institutions as sources of social stability, especially with respect to organizations (Meyer and Rowan 1977; Zucker

1977; DiMaggio and Powell 1983). Increasingly, however, emphasis has shifted to questions of institutional change.

The new institutionalisms have not yet converged on a single language; nevertheless, they generally see institutional change as the process in which the rules (logics, frames, conceptions of control, repertoires) organizing a given field (game, sector, organizational field) are changed (*e.g.* refs?). As long as these rules are reproduced more or less consistently, the institution remains stable and acts as a conservative force, shaping the behavior of actors within that field according to a shared understanding of who is in the game and what the rules are (Jepperson 1991; Clemens and Cook 1999). But occasionally an institutional entrepreneur, often from outside the field, cobbles together a new conception of what rules should govern the field (DiMaggio 1989; Beckert 1999; Fligstein 2001). If such an actor manages to convince enough members of the field to adopt the new conception, the structure of the field can shift radically (Fligstein 1990; Davis and Thompson 1994; Fligstein 1996). The interests of field members may shift in light of the new rules and existing solutions to collective problems may no longer seem optimal.

### *Professional project as institutional transformation*

A professional project is the process through which an occupational group secures a protected market for itself by gaining control over an abstract body of knowledge and the education and entry of practitioners, by gaining legitimacy in the eyes of the public and the state (ideally through a legal monopoly), and by achieving autonomy and self-regulation over its conditions of work (Larson 1977; Abbott 1988). The power/monopoly tradition, which introduced this idea, does not problematize the question of how collective action is achieved (Johnson 1972; Berlant 1975; Parry and Parry 1976;

Collins 1979). To the extent that intra-professional dynamics are examined at all, an economic approach is put forth in which collective action emerges unproblematically given the right configuration of individual interests (see Larson 1977; Jones 1981). But both the study of social movements and historical accounts of professionalization suggest that collective action is something to be explained, not assumed (Tarrow 1998; McAdam 1999; Noble 1977; Peterson 1978; Meiksins 1986; Halliday 1987; Brand 1992).

Starr's (1982) account of the professionalization of American doctors does acknowledge this, and attributes successful collective mobility to the achievement of consensus and legitimacy among incipient professionals. He criticizes the monopolization theorists for "presum[ing] the capacity of a group to articulate its collective interests over its competing interests" and suggests that "[w]hat must first be explained is how the group *achieves* consensus and mobilization" (p. 144, my emphasis). But he argues that mid-nineteenth-century American medicine failed to achieve collective social mobility because of "[m]utual hostility among practitioners, intense competition, differences in economic interest, and sectarian antagonisms" (p.80). This underestimates the possibilities of skilled leadership and organization in overcoming such barriers: English medicine also had all these problems in the mid-nineteenth century, yet managed to successfully overcome them.

I suggest that we can gain insight into professional mobility by highlighting the creation of organizational representatives and the drawing of boundaries. An organizational representative, "in particular the existence of a single, identifiable national association, is clearly a prerequisite of public or legal claims" (Abbott 1988, p. 83). Furthermore, the creation of such a representative involves making important decisions about who is part of the professional project and who is not. Particularly if we accept Abbott's claim that understanding jurisdiction is critical to analyzing the system of professions, it

follows that defining who is in the group that is going to claim jurisdiction matters. A large part of creating a professional project, especially out of a group with a contested occupational identity, is boundary-work (Gieryn 1999).

I further propose that the success or failure of attempted professional projects can be analyzed by explaining them as attempts at institutional transformation. First, the various actors (practitioners, associations, workplaces, governments) that are part of an incipient profession can be thought of as making up a field: they are oriented toward one another, take each other into account when making decisions, and influence each other's course of action.

Second, we can think of the professional project as an attempt to transform the set of rules that govern a particular field. All of the standard goals of professional projects—market control, control over entry, state sanction, etc.—can be thought of as new sets of rules that someone is trying to establish as governing a field. The boundaries of the field—who is a member of it and who is not—are another aspect of these institutional rules, and one which is particularly relevant in understanding how an occupation gets to the point where it can undertake a professional project.

### *Explaining institutional transformation*

Neoinstitutional theorists have been proposed a number of factors to explain institutional change. First, change is seen as precipitated by institutional crisis. Researchers originally conceived of transformations as being caused by some kind of exogenous shock (Krasner 1984). More nuanced conceptions have since been advanced which argue that internal factors like institutional mutability, contradictions, and multiplicity also help explain the origins of change (Clemens and Cook 1999). These do not, however, invalidate the original insight that conditions of crisis—whether created by



dynamics external or internal to the institution—allow the possibility of change. This moment of institutional openness in which change is possible is similar to the social movements concept of political opportunity, which argues that the political world is more susceptible to change through collective action at some times than others (McAdam 1999; Tarrow 1998).

Second, both resources and schemas matter. Resources may be human or material; they include everything from money to social networks to status and are critical in determining whose conception of the field wins in the end. But they are not static, but are enacted through existing frames, models and schemas which provide guidelines for how they may be used—that is, not automatically, but through the agency of skilled social actors (Sewell 1992).

In the early nineteenth century, the field of English medicine underwent a long moment of crisis. A number of organizations tried to reorganize the field; the two I examine had similar resources in many ways. Yet one was much more successful than the others. I suggest that the success of the PMSA and failure of the AASA at redefining the field can largely be explained by two factors: differing locations with respect to the rest of the field, and differing ability to maintain mobilization of their members.

Institutional theory argues that the structure of fields matters for challenging organizations. Particular attention has been paid to how different locations in social networks affect the potential for change (Gould 1993; Padgett and Ansell 1993; Strang and Soule 1998). It has also been suggested that institutional change is more likely to come from actors on the edges of or outside the field since actors who are central to a field are, by definition, those whose existence the institution helps reproduce (Fligstein 1996; Fligstein 2001). The mechanisms through which location with respect to the field help or hinder attempts at institutional transformation have yet to be explored, however (is this true?).

I suggest two ways location with respect to the field affects the success of institutional challengers. First, distance from the field's core may act as a protective mechanism which shields the invading organization from attack, in part because its distance prevents it from being perceived as a threat. Second, location within a field makes a challenger organization much more susceptible not only to direct attack but also to strategies of co-optation in which minor concessions may be made by core organizations but important elements of the existing institutional structure are reinforced.

A number of neo-institutionalists have also noted the similarities between the dynamics of social movements and institution-building (Davis and Thompson 1994; Fligstein and McAdam 1995; Colomy 1998; Rao 1998; Clemens 1998). Their work suggests that successful mobilization of segments of the field or of those outside the field can be a precursor to institutional change. Both neo-institutionalist and social movement theories suggest that institutional entrepreneurs play an important role in creating such mobilization (DiMaggio 1989; Padgett and Ansell 1993; Fligstein and McAdam 1995; Fligstein 2001; Tarrow 1998). Institutional entrepreneurs are socially skilled individuals who help create new collective identities, build alliances, mobilize actors, and engage in a process of bricolage (Douglas 1986) to create new institutional possibilities.

My account highlights the role of collective action in creating institutional change. One of the most important actions of an entrepreneur is choosing an organizational model and then creatively adapting it to fit a new situation. Depending on the structure of the field, some kinds of models may be better than others at mobilizing actors for change. Clemens (1993) suggests that "familiar, but previously nonpolitical, forms of organization" (p. 755) are particularly useful for this. I expand on this insight by showing how different organizational models can interact with the structure of the field in different ways to affect the process of mobilization and thus of institutional change.

## Explaining Organizational Success and Failure

In 1812, a group of London medical practitioners created the Associated Apothecaries and Surgeon-Apothecaries to promote medical reform. The AASA grew quickly and by 1815 claimed 3000 members, between one-third and one-half of all medical practitioners in England (Burrows 1817, p. 6). It had also initiated the Apothecaries' Act of 1815, a major piece of medical reform legislation which for the first time required those who would call themselves apothecaries (*i.e.*, all those who wanted to pursue general practice) to be examined and licensed by other apothecaries. After this landmark achievement, the organization went into decline. By 1817 many of its founding leaders had left and the AASA no longer had much voice in medical politics. The organization lingered on until at least 1843 before quietly dropping out of sight (McConaghey 1972, p. 783).

In 1832 a group of Worcester doctors laid plans for another organization of practitioners. Although its original focus was scientific, the group quickly developed an interest in professional issues, and especially medical reform, as well. Its growth was not so rapid as the AASA's, but it was steady, and by 1845 the Provincial Medical and Surgical Association had almost 2000 members (Bartrip 1996, p. 13). During the 1840s it played a growing role in medical politics as the voice of the otherwise unrepresented provincial practitioners, who made up about 85% of all English doctors. Eventually the PMSA spread to London, and in 1855 it symbolically took its place as the dominant professional organization by changing its name to the British Medical Association.

These groups were trying to create the first modern professional project. They had no obvious model; they were not copying another successful profession. But they saw the rapid decline of the medieval order that had organized English medicine for hundreds of years, and they reacted to it in a very modern way: through entrepreneurial action, they borrowed existing organizational models to

mobilize large numbers of ordinary practitioners in an attempt to create a new order, one that would structure the field in a very different way and one that would have distinctly professional characteristics. It was clear to both groups that the unorganized, unrepresented 85%—the provincial practitioners—were critical to any redefinition of the field. In order for collective mobility to occur, their support would have to be enlisted.

In the new order they envisioned, the provincial majority would also be members of the field. Their voices would matter, and they would be taken seriously. The issues that concerned them would be addressed. All practitioners would be educated, examined and licensed by other practitioners. The uncertified would be legally prevented from calling themselves doctors. And ordinary practitioners would be protected from the poverty made common by a market flooded with too many such doctors with no particular education or qualifications. The AASA and the PMSA were trying to transform the rules that governed the medical field. The first step in doing that was to overcome longstanding dissent within the field and to create a unified voice through which such practitioners could speak.

Both groups were organized during a long moment of crisis in the field. The existing order, in which practitioners were divided among three distinct occupations—physicians, surgeons, and apothecaries—had been in decline since the mid-eighteenth century (cite), and outside of London most doctors termed themselves surgeon-apothecaries and worked in general practice. The three medical corporations—the Royal College of Physicians, the Royal College of Surgeons, and the Society of Apothecaries—still dominated medicine in London, but they had little reach beyond it, and even within it they were increasingly unable to protect ordinary practitioners—that is, the surgeon-apothecaries—from competition from the growing number of druggists and “irregulars” who also treated patients. Demand for medical care was growing with the birth of the middle classes, but so was supply. Medical reform

organizations had been sprouting up since at least 1793 (Good 1795) and a series of Select Committees were appointed by Parliament to examine various aspects of the issue. The push for reform peaked in the 1840s and 50s, when a series of professional bills were proposed, none of which could garner enough support from the contentious doctors to pass. The field stayed in this state of flux until the a compromise bill, the sixteenth bill proposed, was passed in 1858 and a new set of rules, already established in practice, were now legally acknowledged (Newman 1957).

Both groups also had similar financial and human resources. The bulk of the membership of each group came from the provincial surgeon-apothecaries.<sup>1</sup> They were of comparable size. Their leaderships came from different segments of the profession—the AASA was organized by successful London apothecaries, and the PMSA by provincial hospital physicians—but they were segments of roughly equal status and financial circumstances. Both groups raised most of their money from membership dues (one pound per year) and the AASA did not experience financial difficulties that could explain its decline. Both groups experienced early success in mobilizing practitioners and garnering support.

Why, then, was the PMSA able to establish itself as the newly dominant professional organization when the AASA could not? I argue that reframing the goals of these two organizations as not only professional, but as projects of institutional transformation, points us toward an explanation.

**Different locations in the field led to different strengths and weaknesses.** In the first half of the nineteenth century, the English medical field had a core and a periphery. Its core was London, and only in London was the field strong. Practitioners in the provincial periphery were oriented toward London, since London was the location of most hospitals, educational institutions, publications and

organizations. But these London institutions had little direct impact on the lives and conditions of most provincial practitioners.

The AASA was based in the London core of the field, and the PMSA was located in the provincial periphery. Centrality facilitated the early growth of the AASA, since it made meetings and communications easier. But it also led to specific liabilities. First, it made the AASA susceptible to attack from other organizations within the contentious medical field. The PMSA's distance from the field's core sheltered it from such attacks, particularly in its early years of growth.

Second, not only was the AASA physically located in the London core, but its membership also overlapped greatly with that of other core institutions. Most of its founders were members—many prominent—of the Society of Apothecaries or the Royal College of Surgeons, and a number were part of other London medical organizations as well. This intimacy with the London corporations was also helpful in early mobilization, but later proved to be a liability: the AASA suffered from cooptation of its leadership. Its radical goals were redirected in more conservative directions, and its energies were rechanneled back into the existing corporations. The PMSA encountered no such cooptation and remained an alternative to the London corporate structure.

**The organizational models each group chose led to different mobilizing capacities.** The AASA was organized around a model that had already existed in the medical world for at least twenty years and whose structure was shaped by the Corresponding Societies of the 1790s. This model was centralized in nature, based in London and bringing in provincial support through outreach and letter-writing campaigns. It was also explicitly political: from its inception, the only purpose of the AASA was to promote medical reform.

The PMSA, by contrast, was modeled on the British Association for the Advancement of Science, another provincial organization which was founded in 1831. Its structure was decentralized from the beginning, and it incorporated specific organizational features which helped mobilize and maintain a far-flung membership. The PMSA was also founded as a scientific organization whose purpose was to collect and disseminate medical knowledge held by provincial practitioners which was being untapped by the existing London-based societies and publications. Only later did medico-political goals become equally important for the organization.

The different models of organization chosen by each group had unintended consequences in the long run. First, the scientific model adopted by the PMSA proved to be unifying both internally and externally. Internally, it provided a common ground on which those of different political opinion could meet. It helped to maintain a sense of unity and purpose in a group that was trying to deal with difficult professional issues that created rifts in the AASA and in many other organizations. Externally, it acted as a shield. Even once the London corporations were aware of the PMSA's existence and had begun to interact with it, its original purpose as a scientific group made it appear less politically threatening than groups like the AASA, whose sole intention was to reorganize the field in ways less favorable to the corporations.

Second, the PMSA's organizational model kept it focused on a key point the AASA overlooked. Both organizations drew the bulk of their membership from the provinces. But from its inception, a central purpose of the PMSA was pulling together the unorganized, unaffiliated provincial practitioners, and it had structural features—a mobile annual meeting, publications, branches—that made it very good at doing just that. The AASA, by contrast, started by recruiting lots of members from the provinces. But after the first two years, when its organizational resources were pulled

increasingly in the direction of fighting London political battles, its energies slowly turned away from its provincial membership base and it did not manage to keep them mobilized. The ultimate success of the PMSA came from its redefinition of provincial practitioners as truly part of the medical field. With 85% of practitioners living in the provinces and transportation rapidly developing, this eventuality was clear early on. But the AASA, with its London focus, did not keep this in mind, to its own long-term detriment.

*Did twenty years make a difference?*

Even if the field was in flux for an extended period of time, it seems possible that opportunities to create new rules might have been different in 1832 than they were in 1812. Institutional openness is very difficult to pin down, and while it seems clear that before the nineteenth century the field was organized primarily by the London corporations and that by the second half of the century the shift had been made to a national field that was organized into general practitioners and consultants, one might argue that the AASA's failure was not caused primarily by the differences proposed above but by a different political opportunity structure (McAdam 1999; Tarrow 1998).

The eventual failure of two other groups, however, whose models copied the basic organizational model used by the AASA and which were founded in 1836 and 1844, respectively, points away from this hypothesis. The first of these was also called the British Medical Association, and while like the AASA it enjoyed some rapid growth and success in London, by the early 40s it had succumbed to infighting. The second was the National Association of General Practitioners. The NAGP, too, grew quickly, enrolling almost one-third of general practitioners in England and Wales by April 1845, including most of the membership of the first BMA (Loudon 1986, pp. 284-85). It too,



was organized along the same basic model, and it too, suffered from both the attacks of the corporations and failure to keep its membership mobilized.<sup>2</sup>

The AASA was the first and arguably the most successful of these three groups. But the fact that not only did the AASA fail to become the voice of the profession in its day, but that two later groups tried to organize on the same model only to fall to the same problems, along with the eventual success of the PMSA which was based on an entirely different model of organization, suggests that it was not different opportunities that explain success and failure in this case.

### **The Field, the AASA, and the PMSA**

Before discussing the AASA and the PMSA in more detail, it will help to explain what the structure of the field had been like in the eighteenth century and to describe the kinds of changes that were taking place. In the eighteenth century, the three corporations, which had existed in various forms from the medieval era, still dominated the medical field. They had royal charters that gave them legal jurisdiction over all practitioners living within a ten mile radius of London, although they rarely prosecuted the many irregular practitioners within their jurisdiction. Their organization was guild-like and their behavior conservative or even reactionary.

Other institutions in the London field included the seven general London hospitals (two founded in the twelfth century and the others in the eighteenth), many small infirmaries and dispensaries, a handful of medical clubs and societies, and the small but growing medical press (Lawrence 1996; Lefanu 1984). Aside from providing the corporate charters, the state played little role in the field. The field itself was highly fractured and contentious. The corporations each jealously guarded their territory and were

frequently engaged in bitter battles among themselves. Organized demands for medical reform began in the 1790s and at least three reform efforts had already failed by the time the AASA was founded.

Outside London, practitioners were quite isolated. Most were trained by apprenticeship; most worked alone. A few provincial hospitals were founded in the eighteenth century, and these were places where local medical men would interact with each other and sometimes form societies. Almost no provincial practitioners were members of the corporations, and the distinctions between physician, surgeon, and apothecary had little relevance. There were no national organizations.

But things were changing. Demand for medicine was growing rapidly, but the number of practitioners—especially irregulars—was growing even faster. The distinction between the kinds of work done by physicians, surgeons and apothecaries, always blurry, was fast eroding. Education was changing, and it was becoming common for practitioners to follow the traditional apprenticeship with six months or a year “walking the wards” in London. This practice, along with an increasing number of publications and associations and the spread of provincial hospitals, brought doctors—especially provincial doctors—closer together. This was the rapidly changing field into which the AASA and the PMSA were born.

### *The Associated Apothecaries and Surgeon-Apothecaries*

In July 1812, the AASA was founded when several hundred practitioners attended a meeting at the Crown and Anchor tavern to discuss a new tax on glass, a major expense for apothecaries. Talk quickly turned to medical reform, and a committee chaired by the energetic but irascible George Man Burrows was formed to further discuss the issue.

The London Committee, as it would be called, was a group of 34 reputable, well-established practitioners. 26 of these were members of the Society of Apothecaries, and a smaller number were part of the Royal College of Surgeons. They included much of the upper stratum of the Society of Apothecaries, as well as a handful of celebrated surgeons and physicians like James Parkinson, Robert Rainey Pennington, and Anthony Todd Thompson. The Society of Apothecaries contained within it an elite social group of 26 members called the Friendly Society, and 14 members of the London Committee also belonged to the Friendly Society prior to 1815, when the Apothecaries' Act of 1815 was passed (Apothecaries 1775-1810; Apothecaries 1810-1818). Six of the apothecaries and at least one of the surgeons also belonged to the Sydenham Club, another elite group comprised of equal numbers of physicians, surgeons, and apothecaries (Cook 2000). Burrows later claimed that he had “never taken any part in [the Society of Apothecaries’] affairs” prior to the Act (1817, p. 8), but he was elected to the Friendly Society a year after the AASA’s founding (Apothecaries 1810-1818). The members of the London Committee were neither so elite nor so wealthy as those who ran the Royal Colleges, but they were not outsiders to the field. Rather they were men who were successful, well-connected, and who had close ties to other medical organizations—and especially to the Society of Apothecaries.

Burrows and his fellows drew on existing patterns of organization among London practitioners in creating the AASA. Since at least the 1790s, the Crown and Anchor had been a gathering place for apothecaries. The Friendly Society held some of its meetings there (how early?), and in 1794 the General Pharmaceutical Association (GPA) was founded at the tavern. The GPA was an organization of apothecaries which hoped to defend its livelihood from dispensing druggists. Meetings drew several hundred practitioners, and their spokesman, John Mason Good, would later be one of the less active

members of the London Committee (Good 1795). Burrows, too, was a member of the organization, “but almost immediately withdrew, from a conviction of the impracticability of its views” (1817, p. 3). The association petitioned the corporations and Parliament, but had no visible effect and disappears after 1795. It was the first large-scale meeting of its kind (Loudon 1986, p. 138), and was part of the general explosion of associations of all kinds that occurred in Britain during the 1790s (Tilly 1995b, pp. 197-204; Tilly 1995a, pp. 36).<sup>3</sup>

Like the GPA and unlike the PMSA, the AASA had political purposes from its inception. Furthermore, from the beginning it was oriented toward the London medical field and the corporations. It was founded to pursue medical reform; at the second meeting in November 1812 of the full body, the organization resolved that the corporations “be requested to concur and unite in an application to Parliament for an Act for the improvement and better regulation and practice of the apothecary throughout England and Wales” (Surgeon-Apothecaries 1823, p. viii); letters to the corporations followed soon afterward (Surgeon-Apothecaries 1812-1817, item 15). Its explicit goal was one of institutional change: it proposed a fourth corporate body be established by Parliament to examine and superintend apothecaries and surgeon-apothecaries in England and Wales, which would have altered the field’s structure and balance of power significantly, despite its assurances to the corporations that it was “extremely anxious that the regulations to be proposed shall in no degree interfere with their established privileges” (Surgeon-Apothecaries 1823, p. ix).

The AASA was also, from its inception, a centralized organization. The London Committee dominated the group; while it included eight honorary members from outside London, in practice it was run by a small clique of London practitioners. Outreach to the provinces was, however, a goal from the

beginning. The AASA understood that redrawing the boundaries of the field to include the provincial practitioners was critical to the success of any such reform movement.

In November 1812 the organization also resolved “[t]hat country practitioners be requested to form district committees to co-operate and correspond with the London committee on the means best adapted to promote the general and local interests of the profession” (Surgeon-Apothecaries 1823, p. viii). Burrows shouldered much of the administrative burden of this resolution himself, and later claimed that between 1812 and 1815 he personally wrote to 1500 individuals. Outreach also included the distribution of over 40,000 copies of the London Committee’s reports throughout the kingdom (Burrows 1817, p. 6).

Mobilization of distant practitioners was rapid. By January 1813 Burrows reported that “meetings have been held in the counties of Middlesex, Kent, Surrey, Sussex, Hants, Dorset, Wilts, Somerset, Devon, Salop, Worcester, Warwick, Northampton, York, Lancaster, Derby, Lincoln, Cambridge, Huntingdon, Bedford, Bucks, Berks, Herts, Essex, Suffolk, Norfolk, &c. &c.” (1813b, p. 166). By March the list of subscribers (a subscription cost a pound) included over 1100 practitioners, about three-quarters of whom lived outside of London (1813b, pp. 168-172, 258-259, 340-346). That month the “district branches” sent fifty deputies to London for a general AASA meeting (Surgeon-Apothecaries 1812-1817, item 14). But while provincial practitioners were easy to sign up; they proved harder to keep involved.

The corporations responded to the AASA’s initial request for support “with a coldness, bordering on contempt” (Kerrison 1814, p. x), but since none opposed the plan outright the AASA proceeded to present a bill which was first read in the House of Commons on March 8, 1813 (Surgeon-Apothecaries 1812-1817, item 15). The strategy of the corporations had been to avoid

action and delay response as long as possible, but once the bill was submitted the Colleges of Physicians and Surgeons (along with a group of druggists and chemists) immediately petitioned against it (Surgeon-Apothecaries 1812-1817, item 14). In the face of this unexpected opposition, the AASA withdrew the bill on March 26.

The London Committee continued to lobby for the support of the corporations over the summer, since it seemed unlikely that a bill could be passed without that support. It offered to remove any clauses objectionable to the corporations; only the Physicians responded with a curt statement that “the College are of opinion ‘that they cannot give any advice or assistance to [the AASA] on this occasion’”. A third attempt in September met with similar reactions (Surgeon-Apothecaries 1812-1817, item 15).

After the bill was withdrawn in March 1813, the Committee urged the members to redouble their organizing efforts:

District Meetings should be convened in such places where they have not yet been held; permanent Committees be organized, and a correspondence be maintained with each other, and with the London Committee. Subscriptions must be solicited, to reimburse the deficiency in the Fund occasioned by the heavy but necessary expences which have been incurred. Every county, city, or borough, should, by collective application to their Members, secure Parliamentary support, and distinct Petitioners be signed and presented to Parliament for legislative interference and regulation (Surgeon-Apothecaries 1812-1817, item 14).

By September almost £2000 had been subscribed in support of the bill (Surgeon-Apothecaries 1823, p. xl).

### *A Turning Point*

In the autumn of 1813, Sir George Rose, a powerful Member of Parliament who had cosponsored the original bill, interceded personally with Presidents of the Royal Colleges to work on a

compromise (1834, Part III, Q. 259 p. 16; Surgeon-Apothecaries 1823, p. xli). Despite what the Colleges might have wished, it became clear that AASA was not going away, and so their strategy shifted. After Rose's intercession, they decided to work with the AASA, but their support was contingent on the reinforcement of the corporate system: their new position was that they

ha[d] no objection to the formation of a Bill to be brought into Parliament by the London Committee of Apothecaries...Provided the powers therein contained be vested in the Society of Apothecaries...and provided the Bill--before it shall be brought into the House of Commons be submitted to the consideration of the College of Physicians for their examination and approval (Surgeon-Apothecaries 1812-1817, item 16).

This decision marked a turning point for this AASA which eventually led to its decline as an organization. First, it led it to turn its energies away from mobilization. Second, it marked the beginning of a process of co-optation of the AASA's leadership back into the corporate system.

Evidence on the AASA's outreach efforts after this point is scant. What is noticeable is that after 1813, references to the district branches disappear. While the papers of the AASA until that point make regular mention of the extensive correspondence being carried on with the provinces, the number of meetings being held in remote counties, and the attendance at London meetings by those distant members, after the College of Physicians changed its response in January 1814 these all stop. Burrows later claimed that the AASA had 3000 members by 1815 (1817, p. 6), but there is no corroborating evidence for this additional growth and he was prone to overstatement. By July 1817 the secretary refers to the "Provincial Chairmen" in the past tense (Surgeon-Apothecaries 1812-1817, item 20).

I suggest there were two reasons the AASA did not maintain its mobilization of provincial practitioners. First, the AASA lacked specific organizational structures designed for the purpose of maintaining the commitment of distant members. The PMSA, by contrast, had such structures as a result of its choice of a different model of organization, and I will discuss these in detail in a later section. Second, the flurry of activity and negotiation that followed the College's decision was even more

focused on the London field and particularly on the Society of Apothecaries. Having the support of provincial practitioners was important in order for the AASA to get its agenda considered, and it was useful for raising funds. Once a bill seemed to be in sight, Burrows and the London Committee made a strategic mistake: they turned their resources away from mobilizing and toward politicking.

The College of Physicians' placing of responsibility for any bill in the hands of the Society of Apothecaries gave the Society considerable power. The Society was willing to give the AASA access to this power. But there were two implicit conditions. The London Committee would have to devote its resources to working within the Society rather than outside it in its own organization. And the leadership would have to moderate its goals in order to appease the conservative society.

The London Committee originally had no problem with this arrangement. Burrows "sincerely rejoiced", saying that he "knew no reason why it should not by them, as well as by any new and untried body, be administered in a manner as conducive to the welfare of the public as to the interests of the Apothecaries at large. Therefore I most heartily co-operated with the Society, through all its stages, in procuring the passing of the Bill" (1817, pp. 7-8). The membership of the AASA and the Society of Apothecaries overlapped considerably, and a member of the London Committee claimed in 1813 "that of 148 of [the Society of Apothecaries'] members who are Practitioners in London, 110 have concurred in the measures of the Committee" (Committee 1813, pp. 30-31).

The members of the London Committee were familiar with the workings of the Society of Apothecaries and comfortable with it, and they were willing to shift their efforts away from the AASA and into the Society. This may have increased the chances of getting some sort of legislation passed, but, as it turned out, meant that that legislation was much less far-reaching than that which the AASA originally proposed. Working within the confines of an ancient, hierarchical and deeply conservative



corporation like the Society of Apothecaries was much more limiting than working within the newly-formed, basically democratic AASA.

Expanding the AASA's membership was no longer a focus. Influencing the Society of Apothecaries' newly appointed "committee for obtaining an Act of parliament [sic] for better regulating the practice of apothecaries throughout England and Wales" was (Apothecaries 1814-1834). This committee was created on February 17, 1814. A meeting was quickly set up between it and three members of the London Committee—Burrows, Henry Field, and James Upton (Apothecaries 1814-1834, p. 13). Over the next year and a half, the three represented the AASA to the Society's committee (Apothecaries 1814-1834, p. 55). The AASA was perhaps accepted as "the depository of the grievances, the complaints, and the wishes expressed by the Practitioners at large", as Burrows claimed (1817, p. 6). But its new role was to represent these practitioners in the negotiations for a bill as one interest group among many, rather than as instigators and creators of such a bill.

When Burrows presented the compromise bill worked out with the Society's committee to the AASA as a whole in May 1814, it caused an uproar. John Mason Good, the chronicler of the GPA, called it "a measure that had been raked from the musty records in which it had mouldered for two hundred years, to disgrace the enlightened period of the nineteenth century" (1814, p. 510). But after much debate, the bill was accepted by the AASA (1814, p. 524).

The next year involved much negotiating among the various parties in an effort to hammer out the details of the bill. In July 1815 the Apothecaries' Act was signed into law (Loudon 1986, p. 166); on all major points it was similar to the compromise bill set forth a year before. The AASA later called the bill "very unsatisfactory", especially as compared to "the Bill as first projected by the Association" (Surgeon-Apothecaries 1823, p. lviii). They originally hoped to improve it by amendment, but had no

success with this. The AASA continued to meet after the Act was passed, and reported on general meetings in April 1816 and again in August 1817, during which time it was engaged in petitioning against a new bill proposed by the Royal College of Surgeons.

One provision of the Act was that a Court of Examiners be appointed by the Society of Apothecaries to examine candidates for the new License of the Society of Apothecaries (LSA). Shortly after the bill was passed, twelve men were appointed to be Examiners. Among them were Burrows, Field and Upton, as well as five other members of the London Committee (Apothecaries 1815-1819). And the other four members of the Court of Examiners had all signed a petition in early 1813—when the College of Physicians was turning a cold shoulder—which had urged the Society of Apothecaries to communicate with the College in an effort to attain the AASA's goals (Cook 2000). The new Court of Examiners was full of supporters of reform.

Yet the efforts of these reformers had all been turned back into the existing corporate system. The new Act instituted examinations for those who would call themselves apothecaries. But it did not further the fundamental changes that were going on in the medical field. It served primarily to prop up the decaying corporate order.

After the ambiguously worded Act was passed, it quickly became clear that the real power in deciding how it would be implemented lay with the Examiners. And the appointing of the leaders of the AASA to be Examiners had two outcomes: it further directed the energies of the members of the London Committee into the Society of Apothecaries rather than the AASA (the Court of Examiners was a very active body which met for hours each week), and it indirectly fomented dissent and factionalism on the Committee.

A split occurred between two factions of the Examiners, and it quickly spilled over into Committee relationships. One side was fairly conservative and satisfied with the Act; the other (led by Burrows) hoped to amend the Act and thus make it more effective. Burrows was a difficult man and a better organizer than a politician. He eventually alienated not only the conservative faction but also his own supporters, some of whom, like Upton and Field, had been working closely with him for years (Burrows 1817, pp. 11-16). Finally he was forced to resign from the Court of Examiners on March 25, 1817 (Apothecaries 1806-1817; Apothecaries 1815-1819). In August 1817 he resigned as Chairman of the AASA as well, embittered and dissatisfied (Surgeon-Apothecaries 1812-1817, item 20).

This marked the end of an era for the AASA. The London Committee's report from that meeting states:

Five years have elapsed since your committee was appointed; during which, it has been reduced by the death of many valuable members, by secessions and other causes, from forty-five [at its peak] to about twelve or fourteen effective persons...The remaining members of your committee...here surrender the trust which has been confided to them, and which they have endeavoured to execute faithfully and usefully (Surgeon-Apothecaries 1823, p. lxiv).

The AASA lived on in some form until at least 1843 (McConaghey 1972, p. 783), but it never again played an active role in medical politics.

### *The Provincial Medical and Surgical Association*

In July 1832 a group of practitioners in Worcester held the first meeting of the Provincial Medical and Surgical Association. The seeds of the association went back two decades, when Charles Hastings, James Pook Sheppard and Jonas Malden were young practitioners together at the Worcester Infirmary.<sup>4</sup> The three were also members of the Worcestershire Medical and Surgical Society, which

Hastings chaired in 1819 (McMenemey 1959, pp. 39-43). In 1828 Hastings, with the help of Malden, Sheppard, and three other colleagues, founded a scientific journal called the *Midland Medical and Surgical Reporter (MMSR)*. The journal claimed that in France, Germany, and Italy, every region had its own local medical journal, while in England journals were published only in London, and the resources of provincial doctors and hospitals were remaining untapped (McMenemey 1959, p. 57). It met with success and was published for four years, ceasing only with the demise of its publisher (Bartrip 1996, pp. 4-5). However, in the last issue (May 1832), a prospectus was issued suggesting “that the Members of the Profession, residing in the Provinces, should unite themselves into an Association *friendly and Scientific*” (1831-1832, pp. 302-303). Shortly thereafter the first PMSA meeting was held at the Worcester Infirmary.

The PMSA was an immediate success. Hastings had recruited 150 candidates for membership by the first meeting (Association 1832, p. 30). Almost all were from the provinces; most were from the midlands (Association 1832, pp. 36-46). They were a group much less well-connected to the corporations than the members of the London Committee, but many of them had positions with the various provincial infirmaries, a sign of the local medical elites. They included physicians and surgeons, almost all of the latter of whom were general practitioners and would have fit under the label of “surgeon-apothecary”. They were much less isolated from each other than their peers fifty years earlier, but they still had no “system of co-operation...for the promotion of our knowledge of the healing art” (Association 1832, p. 3). Hastings’ hope was to promote such a system.<sup>5</sup>

Provincial doctors were key to the great growth in scientific societies that occurred in the early part of the nineteenth century (Thackray 1974). Bartrip notes that several founding members of the PMSA were also active in the Society for the Diffusion of Useful Knowledge; he gives examples of

several other active PMSA members who were prominent in local scientific and philanthropic associations (1996, pp. 11-12); Inkster makes a convincing argument that medical men were at the heart such associations in Sheffield (Inkster 1977).

Hastings also borrowed another model of organization, that of the British Association for the Advancement of Science (BAAS), a group founded in September 1831 at York, in his attempt to create a community of provincial practitioners. The BAAS was another provincial scientific group, more general in scope, which had met again at Oxford the month before the first PMSA meeting (Morrell and Thackray 1981). There is some doubt about whether the BAAS served as a direct model or not, in part because Hastings later made different claims about the extent of its influence. Hastings may or may not have been at the first meeting at York, but he was certainly at the Oxford meeting in June 1832 and was listed as a member in 1833 (Bartrip 1996, pp. 8-12; McMenemey 1959, p. 4). Similarities between the two organizations point to at least indirect influence, though.

Two references to the BAAS were made in Hastings' inaugural speech, and in one he suggests that the PMSA would do well to imitate it (Association 1832, pp. 4, 12). John Connolly, another founding member, also said at that meeting that "[t]he importance of such an association as it was proposed to establish, was deeply impressed on his mind since he attended the meeting of the British Association lately held at Oxford" (Association 1832, p. 31). Like the BAAS, the culminating activity of the PMSA was to be an annual meeting, to be held in a different provincial town each year (Association 1832, p. 11). And like the BAAS, its purpose was to spread scientific knowledge through the provinces.

The other primary activity of the early PMSA was the dissemination of its *Transactions*, an annual volume along the lines of the *MMSR*: The *Transactions*, like the *MMSR*, was primarily a

collection of papers on scientific subjects rather than professional issues. The first volume was published in 1833; it was subsequently sent to all members for their annual subscription of one guinea.

Hastings' initial goals for the PMSA were mainly scientific. The association's prospectus listed five, the first four of which were science-related and only the fifth of which, "Maintenance of the Honour and Respectability of the Profession generally, in the Provinces, by promoting friendly intercourse and free communication of its Members; and by establishing among them the harmony and good feeling which ought ever to characterize a liberal profession", was professional in nature (1831-1832).

Hastings' opening speech to the PMSA emphasizes his hopes for the association's advancement of medical science and his sense that provincial practitioners were a gold mine of underutilized knowledge.

Furthermore, even the secondary social purpose of the association was far from political. In its first few years, the PMSA expressed no interest in the raging debates about medical reform and the state of the profession that were going on in London. In fact, little reference was made in the minutes to the corporations at all, or to the self-contained world of London medical politics that so dominated the attention of the AASA. As one member commented in 1835, "The Hall and the College leave us to ourselves".<sup>6</sup> The organizations that *are* referred to occasionally in the minutes are provincial scientific societies: the BAAS, the Birmingham Philosophical Institute, the Buckinghamshire Medical Association, the "scientific societies of Manchester", for example (Association 1834-1847). In contrast with the AASA, the PMSA initially had no interest in changing the rules of the medical field. Both its isolation and its comparative indifference to the field served to protect it from both attacks and co-optation of the kind experienced by the AASA.

The PMSA did not experience the rapid membership growth of the AASA, but it still grew at a brisk pace in its first decade. From its initial 150, it grew to 600 by 1832, and reached the thousand-

member mark in 1838 (Bartrip 1996). The annual meetings attracted sizeable fractions of the membership; the minute book lists 191 attendees at the 1835 meeting in Oxford, when there were 500 members total. The steady growth suggests that the PMSA was filling a need for these practitioners. In 1836 the President concurred, saying that “[s]uch opportunities as these were almost the only means that Medical Men had of seeing gathered together much that was estimable in their profession and enjoying that intercourse of those means of communication from which under ordinary circumstances they were debarred” (Association 1834-1847). Hastings’ goal of building a provincial medical community was meeting with success.

The practice of having the annual meeting in a different town each year proved to be useful for mobilizing members. Each year, a meeting place was selected for the following year and a distinguished practitioner from that town was elected President. The task of organizing an annual meeting helped mobilization in the town where it was to be held; each year, many new members were pulled in because the annual meeting was held locally and then went on to continue attending even when it was more distant. Meetings were held in Bristol, Birmingham, Oxford, and Manchester; as the PMSA grew they were held further afield in York and Cambridge as well. A focus on communications was also important in maintaining the connection of the membership; in addition to the *Transactions*, committee reports and speeches from annual meetings were published and distributed (e.g. Association 1832; Association 1833; Association 1836; Crosse 1836; Association 1839). The intentionally decentralized structure of the PMSA, organized on a different model from the AASA, contributed to its success at building community among practitioners. The mobile meetings were novel (Thomas Wakley’s *Lancet* regularly derided the organization as the “migratory doctors” or the “migratory medical club”), but effective.

One other successful innovation of the PMSA was its adoption of a branch structure to support the central organization. Branches were part of Hastings' plan from the beginning, and were mentioned in the organization's prospectus, although it took a few years for them to develop. The first began in August 1835, when John Green Crosse, a Norwich practitioner who had attended the first few annual meetings, published a letter to the editor in five eastern newspapers suggesting that an "Eastern Association" be formed with the ultimate intention of becoming a branch of the PMSA, described as an "extensive society already existing in the wester part of the kingdom". 140 practitioners signed a call for such an organization, and 70 to 80 practitioners attended its first meeting the following month in Bury St. Edmund. By the following June this new group had 170 members and was seeking to join with the "Parent Provincial Association" as its first branch (Association 1835-1842). This move increased the PMSA's membership substantially, from 600 in 1836 to 940 in 1837, and increased its geographic spread accordingly (Association 1834-1847).

Other branches quickly followed. They are difficult to track, since a number of them came into existence for a short time and then disappeared, and others changed names, merged, or split. In 1837 an official set of rules for branches was approved. And between 1837 and 1842 Wells, Bath, Southampton, Shropshire and North Wales, Newton, Bristol, East York, Yorkshire and South Western branches are mentioned (Association 1834-1847). Unlike the District Branches of the AASA, which were organized from the top down, the PMSA's branches grew from the bottom up. Some, like the Eastern, were newly organized; a number of others were already established as local medical societies. The PMSA's adoption of them as branches strengthened the organization while it provided national connections to the local groups. This co-optation of existing local networks of practitioners made the PMSA's branch organization more durable than that of the AASA.



### Entering the Medical Field

The 1835 annual meeting found the PMSA's Council reporting for the first time on an issue of medical politics. The New Poor Law of 1834, while "designated by historians as a distinct watershed in the provision of medical services for the poor, marking the beginning of an improved and widening range of facilities", caused substantial economic hardship to many provincial doctors (Marland 1987, p. 70). Before 1834, contracting for care of the poor had been a substantial and regular source of income for many provincial doctors. Under the new bill, wages were lower, workloads were higher, patients were farther away, and practitioners had less authority to care for patients as they saw fit (Marland 1987, ch. 3). PMSA members objected to all of these changes, and the meeting established a Poor Relief Committee.

This is the first venture of the PMSA into medical politics, and it occasioned comment. A Mr. Smith of Southam who was on the Poor Relief Committee felt it necessary to justify this new direction:

A few of such, may be disposed to postpone an Inquiry, or stifle a discussion, not so directly liberal and scientific, as those subjects are, which have usually occupied their attention, but I beg to remind the most profound enquirers into the Arcana of Nature's Mysteries, that ours is a practical as well as speculative Act; and that whatever will enable us to act more extensively, conveniently and lucratively in the real concerns of life is as truly important and as much deserving of attention by Practical Men, as the more profound speculations of Science (Association 1834-1847).

The next year this committee published a report; it was followed by a petition to both Houses of Parliament (Association 1836). Copies were sent to the three corporations, with a request for their cooperation (Association 1834-1847). This marks the PMSA's first interaction with those bodies.

After the Poor Relief Committee's establishment, interest in other medico-political issues follows. In 1837, for example, the PMSA resolves: "That it appears desirable to this Meeting that the Members of the Association in their several localities should urge upon the Members of the Legislature

the importance of an enlightened consideration of the questions touching the public health pending in Parliament” (Association 1834-1847).

These events mark the beginning of the PMSA’s gradual turn from scientific goals to professional ones. Also in 1837, a committee of nine members was appointed “to watch over the interests of the profession at large” (Association 1834-1847). In 1840 the *Provincial Medical and Surgical Journal* (*PMSJ*, later the *Association Medical Journal* and then the *British Medical Journal*), a weekly journal, was founded independently of the PMSA but aiming at *PMSJ* members as an audience and “emphasizing that the goals of the *PMSJ* were those of the Association” (Bartrip 1990, p. 14).

The establishment of the *PMSJ* both reflected the PMSA’s turn toward professional goals and strengthened its ties to its membership. The former was now an explicit goal: “the advancement of the profession, especially in the provinces, and dissemination of medical knowledge” being the *PMSJ*’s objectives (Bartrip 1990, p. 15). Hastings was in full support of this mission and at the 1841 meeting emphasized the importance of having a more regular means of communication than that provided by the *Transactions*. He claimed that

[t]his consideration has for some time been present to your Council and they have long been of opinion that a weekly periodical journal, in connexion with the association, would form an appropriate vehicle for these communications....They could not conceal the fact, that a periodical publication which would bring the members of the association into weekly communication, and afford a powerful organ through which their opinions might be heard when occasion required, would be highly advantageous, by combining their exertions and concentrating their opinions (Association 1841).

Shortly thereafter a deal was established through which all PMSA members received the *PMSJ* as part of their membership subscription. Membership growth had slowed in the past few years and the introduction of the *PMSJ* provided a boost in membership of perhaps 50% (McMenemey 1959, p. 208; Bartrip 1990, p. 16; Bartrip 1996, p. 13).

Another 1841 event marks the PMSA's full entry into the soon-to-become national medical field. The British Medical Association (no relation to the PMSA/BMA) was another reform group based in London and founded in 1836 on a model similar to that of the AASA. In 1841 this BMA organized a committee of representatives from various medical associations to work toward reform. The PMSA had by far the largest membership; it was to have eight representatives on the committee, the BMA six, and seven other smaller associations one each. The meetings began on February 3, 1841 but quickly became acrimonious and then deadlocked, as London medical politics often did, and within a few weeks four of the PMSA representatives resigned in frustration. By February 16th the chairman of the conference followed, since he did not think the remaining delegates were representative of the profession. The only tangible outcome of this meeting was lasting bitterness between the PMSA and the BMA (McMenemey 1959, pp. 213-222).

What is important about this event, though, is that it marks the point at which the PMSA tentatively entered the London medical field and was unceremoniously introduced to its partisan battles. Once this step had been taken, there was no going back. The PMSA had begun to conceive of itself not just as a scientific organization, but as the representative of an ever-growing fraction of practitioners who had no other voice in the medical field. As such it could not stand by on the increasingly hot issue of medical reform.

The period of the 1840s would be a period of battles. As the PMSA became increasingly entangled in the medical field, the purpose of the organization was put into question. It seemed necessary to some that a London base be created and its practitioners included if the organization were to play an effective role in medical politics. Others were less interested in moving in this direction, and preferred to maintain its provincial and scientific character. Fierce debates raged over which was the

best course for the organization, and rifts were created. In the end, a middle course was taken: the PMSA gradually turned toward London, but it did so slowly and cautiously. Not until 1853 was publication of the *PMSJ* moved to London; that same year a Metropolitan Counties branch was finally established. They were entering the field, but they were doing so slowly, and they were still outsiders (Bartrip 1996, ch. 2). Their distance from the field's core meant that even when they did participate, they were not perceived as a threat. Even in their campaign for the Medical Act of 1858, Stokes writes that the PMSA was, "once they had provided the initial spur to reform, an irrelevance" (1989, p. 353). Hastings' conservatism about how much to participate in the field protected the PMSA while from the outside they continued to redefine it.

While pressure had been mounting from some quarters within the organization to make these changes since the mid-40s, the conservative course may have ultimately saved them. Other popular London-based organizations of practitioners were being chewed up and spit out by the still-powerful corporations in the battle for a medical reform bill. The PMSA's perceived irrelevance continued to protect them, even though they continued to grow. Its continuing focus on science provided a shared frame for its membership and gave them a common ground on which to stand, even when internal dissent over the purpose of the organization was strongest. And the structures it established for mobilizing distant practitioners—the traveling meetings, the *Transactions* and then the *PMSJ*, the bringing together of practitioners with no other means to meet—continued to serve it well. Its success at this is indicated by the enthusiasm with which Londoners joined the new Metropolitan Counties branch of the PMSA: this is an indicator both of its being perceived as having something to offer and that, increasingly, London practitioners were thinking of the field as national as well. By the time the PMSA changed its name to the British Medical Association in 1856, it still might not have had much

voice in medical politics, but it was well on its way to redefining the medical field—who was part of it, and who would be represented—and it was well on its way to its future role as representative of the profession.

### **Conclusions**

The professions literature does not have much to say on the question of how collective action is put together. I suggest that understanding a professional project as a project of institutional transformation gives us insight into the processes of mobilization and boundary-drawing that are a necessary condition for collective mobility to occur. English doctors created one of the first professional projects, despite conditions of internal division that made such collective action look extremely unlikely. But they did not manage to create an organization to represent the incipient profession on the first try. Both the AASA and the PMSA had institutional entrepreneurs who creatively manipulated familiar organizational models in an effort to create such a representative body. But only the PMSA was ultimately successful in this effort.

Both groups had political opportunity; both groups had similar material and human resources. But two differences were key to the success of one group and the failure of the other. First, one group was located on the periphery of the existing medical field while the other was located in its core. Distance from the core acted as a shield for the PMSA, while the AASA's location made it susceptible not only to attack but to co-optation from other organizations.

Second, the choice of models the two organizations used had very different effects, given the structure of the field. The decentralized aspect of the PMSA's model proved useful in not only getting but keeping distant practitioners connected, unified, and mobilized. The scientific aspect of it provided a

common ground for action that could be maintained even when the political goals of the organization were in question. Both aspects helped shield it from attack by helping it appear unthreatening to the powerful corporations in the field's core.

The AASA, by contrast, chose an organizational model that was both centralized and explicitly political. This not only exposed it to attack and co-optation by other organizations in the core, but also led it to make a tactical error about how to deploy its resources. Its shift in focus from mobilizing provincial practitioners to politicking with the corporations caused led to a loss of their support and, in part, to its eventual co-optation and decline.

The PMSA, though a more conservative organization than the AASA in some ways, provides an excellent example of institutional entrepreneurship. Through the novel deployment of an existing organizational model, it successfully mobilized—and kept mobilized—the unorganized, unrepresented majority of practitioners. In the process it managed to redefine the boundaries of the field and its membership. The PMSA unified the profession; only then could collective mobility be achieved.

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<sup>1</sup> By the time the AASA was founded, there was no real difference between the surgeon-apothecary and the general practitioner; the older term was gradually being replaced. Some thought the AASA's name archaic; the organization eventually did change its name to the Associated General Practitioners. The AASA and the PMSA consisted of the same men doing the same work.

<sup>2</sup> See McConaghey (1972) on the history of the NAGP.

<sup>3</sup> It is possible that the GPA and the AASA were influenced by the London Corresponding Society. Parkinson, one of the most active members of the London Committee, was once a spokesman for the LCS (Parkinson 1794; Parkinson 1795; Thompson 1963, pp. 133, 138).

<sup>4</sup> None of them seem to have been members of the AASA; however, Sheppard was listed as a member of the Society of Apothecaries in 1813 (1813a). Hastings and Malden were finishing their studies in Edinburgh at this time. The medical world was a small one, though, and Hastings' brother would later marry George Man Burrows' daughter (McMenemey 1959, p. 217).

<sup>5</sup> Provincial practitioners were quite isolated in the eighteenth century, but changes in medical institutions led to the development of much denser professional networks among them between 1790 and 1850. Three of these changes were particularly significant: 1) the establishment of provincial hospitals, which became the center of local medical communities, provided more opportunities for doctors to interact with each other either in the course of their work or through meetings of local medical societies (see Farr 1838 for a contemporary list of provincial medical societies); 2) a shift in education from apprenticeship-based to hospital-based meant that young provincial practitioners (who increasingly traveled to London to study) had more opportunity to interact with their peers; and 3) the medical press, which grew enormously during this period (Lefanu 1984), enabled provincial practitioners to receive regular news

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about the emerging national medical community for the first time. Lawrence (1996) argues that the growth of London hospitals led to the creation of a London medical community between 1760 and 1815. My research suggests that a similar process happened in the provinces about thirty years later.

<sup>6</sup> That is, Apothecaries' Hall, home of the Society of Apothecaries, and the Royal College of Surgeons.

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