GETTING A MEDICAL QUALIFICATION IN ENGLAND IN THE NINETEENTH CENTURY*

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The first half of the nineteenth century was a time of great social and political change and turmoil; this was reflected in what subsequently became the medical profession.

Before 1815

In the early years of the century, successful completion of an apprenticeship was all that was needed for entry into 'regular' medical practice, but there were, nevertheless, medical qualifications to be acquired by those so inclined. These were to be obtained by examination from 8 universities (2 in England, 1 in Ireland and 5 in Scotland — 2 of them in Aberdeen) and 7 Colleges of Physicians and Surgeons (2 in England, 3 in Scotland and 2 in Ireland). There was also Apothecaries Hall in Ireland and, although he rarely did so, the Archbishop of Canterbury could grant the Lambeth MD. Membership of the Society of Apothecaries was acquired by examination by those wishing to practise in London.

Medical practitioners were divided fairly rigidly, at least as far as formal affiliation was concerned, into physicians, surgeons and apothecaries, but once in practice a man who had been apprenticed to a surgeon might also practise as an apothecary (and vice versa), giving rise to the common description 'surgeon-apothecary'. The 'system' had not kept up with reality. All were engaged in general practice to some extent, with the possible exception of a very few pure physicians and even fewer pure surgeons, mainly in London. All were in serious opposition to each other since the profession was overcrowded, numbering at least 1 to about 1100 population around 1815. It must also be remembered that at that time the Napoleonic wars were drawing to a close, releasing into civilian practice large numbers of military and naval surgeons, many of whom had had only the most superficial training before joining the armed forces.

The physicians were ruled over by their own Royal College whose Fellows were drawn from Oxford and Cambridge graduates. Their claim to control the practice of medicine was based on the Charter granted by Henry VIII which gave the Fellows and their licentiates the exclusive right to practise as physicians in London and for seven miles around. The College also granted an 'extra licence' which alone permitted the holder to practise as a physician outside the seven mile limit. This was a theoretical restriction, since although the College might have the power and the will, it did not have the means to police it. The Royal College of Physicians did not have a first qualification until 1860, when the Membership examination was instituted as the qualification for physicians and the Licence (LRCP) which it replaced was recast into a complete first qualification by the addition of surgery and midwifery to its requirements.

Acquiring a medical degree at Oxbridge was largely a matter of studying the writings of the physicians of classical times such as Hippocrates and Galen. In the final

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examination, the student had to defend in Latin, before the Professor of Medicine, two 'theses' (or, points of view). He could choose the topic of one of these himself; he then had to defend a further thesis to a fellow candidate. It was acceptable to pay someone to do this for you.

The London surgeons broke away from the Barber-Surgeons Company in 1745 to become the Surgeons' Company and were granted a new charter in 1800 as the Royal College of Surgeons (RCS) of London. They were not as academically-minded as the physicians, regarding their calling as a practical one to be taught to the student by precept and example. To this end the hospital surgeons took on a few pupils, potential 'pure' surgeons, to act as assistants — the equivalent of dressers — at a premium. They allowed other students to see them at work, also at a premium, though a smaller one.

Hospital medical schools were in the process of becoming established, although much medical teaching (particularly in anatomy) was done at private schools in both London and such provincial towns as Liverpool, where lecturing in anatomy and surgery started at the Dispensary in 1812 and in physic and materia medica in the next year. The most famous private medical school was that established (eventually in Great Windmill Street) by William Hunter and at which John Hunter taught up to 1760.

The qualification given by the RCS was the Membership, the regulations for which required, in addition to an apprenticeship, attendance at one session of anatomy and one session of surgery. The examination was an oral one, but the successful were regarded as sufficiently qualified to go into general practice or enter 'pure' surgery which was at that time in a fairly primitive state. Operations were few. For instance, at Glasgow Royal Infirmary in 1800, 41 operations were done on 803 patients (or a ratio of 0.05 operations per patient). By 1840, the rate had fallen to only 120 on 5185 patients (1:0.023).

Some apothecaries kept open shop for the dispensing and sale of drugs and medicines in much the way that pharmaceutical chemists do now and the question, 'Have you got anything for such and such?' must have been heard as often then as now, leading to much over-the-counter treatment. The difference was that the apothecaries also visited the sick in their homes. In the towns, they were the doctors of first resort for the poor and treated the minor illnesses of those who were then called 'the better sort'. In country districts apothecaries and surgeon-apothecaries looked after almost everyone. They could charge for any medicines provided, but not for attendance or advice, a decision of the House of Lords in 1703. They took on apprentices who signed indentures for at least five years and paid a premium to be taught the trade, the doctoring as well as the dispensing side. Those who wished to practise in London then presented themselves before the Society of Apothecaries where, as with the RCS, the examination was in the form of a viva. There is no doubt that many went beyond the minimum requirements and also attended Hospitals and Dispensaries.

The principal disadvantage of the apprenticeship system was that the level of teaching, whether received from a surgeon or an apothecary, was very variable. Some former apprentices tell of serious teaching being done, but there are also many who tell of exploitation as bottle-washing drudges and of being kept in the shop learning the minimum while the master was out on his rounds. At best such apprentices prescribed for those whom the master regarded as of too low a social status for him to be bothered with and did the occasional blood-letting or tooth extraction. At the end of the apprenticeship,

whether well taught or not, the apprentice was regarded as a trained man, free to set up on his own.

The Apothecaries Act 1815 and its sequelae

Discontent in the profession led to pressure for reform of the medical setup and for suppression of practice by so-called quacks and bonesetters, but the London Colleges of neither the physicians nor the surgeons were willing to have anything to do with 'general practitioners', as they were coming to be called. Ultimately, the Apothecaries Act 1815 thrust on to the hapless Society of Apothecaries the responsibility for organising qualifying examinations and hence for determining the content of basic medical education, a remit which endured until 1858.

The Act was a compromise, passed by one vote on the last day of a busy session of Parliament which was no doubt rather more interested in the settlement of Europe. Its main features were:

- The Society of Apothecaries became the main examining body for entry into general medical practice
- A five year apprenticeship was compulsory
- The holder of the Licence of the Society of Apothecaries (LSA) must be willing to dispense physicians' prescriptions
- The LSA was compulsory for all who dispensed

Throughout the nineteenth century the medical teaching year was divided into a winter session of six months starting in October and a summer session of three months starting in May. This was largely because practical anatomy on the fresh corpse had to be a winter activity. The early regulations for the LSA called for attendance at not less than one course of lectures in chemistry and in materia medica and medical botany (the main reason for failure in the examination for the LSA in the first several years after 1815 was insufficient Latin), two courses of lectures in anatomy and physiology and two courses of lectures on the theory and practice of medicine. Candidates had to attend the medical practice of some public hospital or infirmary for at least six months or nine months at a dispensary. Candidates were also recommended to attend one or more courses of lectures on the diseases of women and children. Childbirth was universally thought of as a natural process and midwifery not a subject for medical examination, although this attitude was to change in 1827.

It will be seen that the study of surgery was not even mentioned. This was because apothecaries were only expected to deal with internal disease, where medical treatment unaided by manual procedures was called for; anything external such as a wound, a fracture or a swelling was the province of the surgeon, as were skin diseases since these too were external.

The LSA was compulsory for all who wished to provide medicines for their patients in general practice. This rule penalised those who had taken a medical degree at a Scottish University for they were excluded from practising in England even though they could claim, with justification, that they were better educated than those with the LSA only.

Although it was not obligatory for general practice, most candidates for the LSA entered themselves for the MRCS as well. This was popularly known as 'going up for College and Hall'. In 1823 the College of Surgeons introduced a rule that certificates of instruction in anatomy submitted by candidates for membership would only be accepted if the instruction had taken place during a winter session. This was a severe blow to the private schools (where much of the medical teaching throughout the country took place, particularly in anatomy), some of which had introduced methods of preserving corpses so that summer dissection was possible. In 1824 a further rule restricted acceptable certificates to those from Edinburgh, Glasgow, Aberdeen, Dublin and 'approved' centres in London, principally the hospital medical schools where the anatomy and physiology were taught mainly by surgeons who were on the council of the College of Surgeons. This caused great difficulty in obtaining sufficient corpses in London for the increased number of students crammed into the winter session, the majority of corpses being got from resurrection men who sold them to the anatomists. Despite public outcry Parliament did not act until 1832 when the Anatomy Act allowed the use of unclaimed bodies from workhouses, prisons and hospitals. The RCS relented to the extent of accepting certificates from a much wider field of provincial schools.

This period saw three other innovations, all from Cambridge. In 1829 attendance at lectures became compulsory, a written paper was included in the MB examination and in 1842 a clinical examination was introduced.

By the middle 1840s the medical course had generally become 4 years long. The MRCS now required experience of midwifery (including 6 deliveries), a course of lectures on physic, and one winter and one summer session in the hospital practice of physic. The requirement for the hospital practice of surgery was three winter and two summer sessions. The LSA course, now 3 years long, included practical midwifery and 18 months practical medicine, but still no surgery.

However, agitation for reform of the profession and rationalisation of medical education continued unabated after 1815. Thirty-two unsuccessful medical bills were introduced in the subsequent 43 years before, in 1858, Parliament did pass the Act for the Regulation of Qualifications of Practitioners of Medicine and Surgery, which established the General Council for Medical Education and Registration, now known as the General Medical Council (GMC).

The Medical Act 1858

The main provisions of the Act were:

- to set up the General Medical Council and Branch Councils
- to establish a Register, published annually
- to decide which qualifications were registrable
- to establish a disciplinary code
- to supervise examinations and be cognisant of courses of study
- to publish a Pharmacopoeia
- to permit the recovery of fees
- to nominate Offices and Functions restricted to registered persons
- to abolish geographical restrictions on practice

The Act nevertheless had its weaknesses. Single qualifications were to be registrable; this meant the inclusion of the names of holders of the MRCS (with little training in medicine), the LSA (with no training in surgery) and the Licence in Midwifery. In addition, the GMC was to have no authority over the content of curricula in medical schools, its power in this area being restricted to right of access to examinations.

Moreover, the profession was still upset at the Act's failure to suppress 'quacks', as in 1815. However, Parliament's aim was to set up the Register so that the public could see for itself who had pursued an approved course of instruction and who had not. The idea was to protect the public, not the medical profession.

The registrable qualifications comprised the degrees of all the Universities and the licences of all the corporations. Those who had been in practice before the 1815 Act was passed were also deemed to be registrable, whether or not they had any qualification. Also included were those who held the Licence in Midwifery which the RCS had recently instituted, even though candidates for this licence were not examined in medicine and surgery.

Medical students had a poor reputation for rowdy and coarse behaviour and for being poorly educated; the General Medical Council spent a lot of time considering and designating preliminary educational standards for medical students, who had to be registered with it. There was anxious debate as to the desirability of making Greek a compulsory subject, though nothing came of it. A particular target of complaint was poor spelling, but I suspect that the young have always been accused by their elders of being poor spellers.

The 1858 Act tried to reduce the number of qualifying examinations by encouraging Corporations and Universities to amalgamate. The ideal sought by John Simon (Medical Officer to the Privy Council), enthusiastically supported by Thomas Wakely (the outspoken editor of The Lancet), was a single examination nationwide, the so-called 'single portal of entry'. However, this was not acceptable to the universities or the corporations and the multiplicity of qualifications has persisted to the present day, to the astonishment of the rest of the world.

Some rationalisation did take place. In 1859 the Double Scottish qualification came into being by the amalgamation of the examinations of the Royal College of Physicians of Edinburgh with the Royal College of Surgeons of Edinburgh and with those of the Faculty of Physicians and Surgeons of Glasgow. The RCP instituted the MRCP and changed the LRCP into a first qualification, so opening the way to the establishment of the Conjoint Qualification of LRCP.MRCS in 1884. In 1860 the two Aberdeen Universities became one. In 1886 the three Scottish corporations combined their qualifications into the 'triple Scottish'. On the other hand, there was an increase in qualification granting bodies when Owen's College (Manchester having become Victoria University in 1880) was empowered to grant medical degrees in 1884 in which it was joined by University College Liverpool, founded in 1881.

The pattern of the medical course was now much as it is generally known in Britain today, with anatomy, physiology and possibly materia medica preceding clinical studies, instead of their being all mixed up as they had been previously. (This change was largely because the medical schools now offered a structured syllabus). Yet, many students continued to wander from lecturer to lecturer and from school to school, each

constructing his course as he went along. I say 'his' advisedly since women medical students were unknown (apart from a very few hardy pioneers) until 1874 when the London Medical School for Women opened with 6 students.

Women generally met with rebuffal from both the Corporations and professional bodies such as the BMA. When, in 1875 three women offered the requisite certificates of satisfactory study to the RCS with a view to being examined for the Licence in Midwifery, the College sought to exclude them. The College took Counsel's opinion and was told that as the certificates of study submitted were more than was required by the regulations, the ladies must be examined. The ingenious but distinctly caddish solution adopted by the examiners was to resign; they were not replaced and the diploma was suspended. All the women had studied in Edinburgh, but none was allowed to sit the qualifying examinations. One of them was the redoubtable Sophia Jex-Blake who went off to Berne, where she obtained the MD. This was not registrable with the GMC, so she next went to Dublin, qualifying the following year with the Licence of the Kings and Queens College of Physicians (to become the Royal College of Physicians in Ireland in 1893). Jex-Blake eventually founded the Edinburgh School of Medicine for Women.

The Medical Act 1886

Some of the remaining deficiencies in nineteenth century medical education and organisation were rectified by the important Medical Act of 1886, of which the main provisions were:

- the establishment of integrated qualifications in medicine, surgery and midwifery
- the recommended combination of licensing bodies
- no candidate to be excluded for adopting a particular theory of medicine
- provision for the admission of women [not put into effect in Liverpool until 1903]
- no geographical restriction on practice in Britain
- direct representation of medical practitioners on the General Medical Council (two representatives for England, one each for Scotland and Ireland)

Yet, diversity remained. The 1882 Medical Directory reveals that the 255 recorded as having been students at Liverpool at some time boasted between them 14 different first qualifications:

MRCS	108
LRCPE	58
LKQCP	37
LSA	22
LFPSG	10
MD QUI	5
MB CM Ed	3
LRCP	3
MD St And	2
LRCSE	2

LAH	2
LRCSI	1
MB CM Aberd	1
MD NY	1

A further very striking characteristic of these Liverpool alumni in the 1882 Medical Directory is that two thirds of them had studied at at least one other medical school in addition to Liverpool; only one third of those in the 1902 Directory had done the same. By the end of the century the pattern had changed completely with the introduction of the MB,ChB (Victoria) in 1884, of the Conjoint Examination in 1886 and the MB.ChB (Liverpool) in 1903.

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