‘Medical Doctors and Persuasion: Introduction’

Catherine Kelly and Joan Tumblety

In 1848, John Simon, Medical Officer of Health for the City of London, wrote that, ‘[t]he frightful phenomenon of a periodic pestilence belongs only to defective sanitary arrangements.’[1] In so doing he followed what was to become, for him, a practice of using his annual reports on the sanitary condition of London to advocate for environmental measures to promote urban sanitation and hygiene. He bolstered these efforts, using his close connections at *The Times* to win the support of the public. As is well known, his work is widely credited with the passing of the Sanitary Act 1866. Simon is only one (extremely successful) example of a large number of medical practitioners who attempted to change the course of what we would now call ‘health policy’ by exerting influence on political elites, the public and other practitioners over the course of the long nineteenth century.

Today we would label Simon’s activity lobbying. By the middle decades of the nineteenth century the professionalization of medicine meant that medical practitioners were more organised than ever before. The expansion of state bureaucracy and the increasing ease of communication that accompanied industrialization meant that they had more opportunities to exert an influence on public policy around health. The exploration of the medical, political and cultural dynamics that informed this process underpinned a workshop on ‘Physicians, persuasion and politics: lobbying and culture in Britain and France, c.1780-1940’ that we hosted at the University of Southampton in July 2015.[2] This volume represents both a

[1] *Sanitary Condition of London*, 1848-9, p.7

[2] For a brief overview of the theme, see Catherine Kelly, Joan Tumblety and Nick Sheron, 'Histories of medical lobbying', *The Lancet*, no. 388, 22 October 2016, pp. 1976-77. We thank the Society for the Study of French

deepening and a reframing of those early discussions around the problem of medical lobbying in the modern era. Insights from that workshop revealed that our initial enquiry was too narrow and too politically focussed. Perspectives from cultural history and the history of emotions clearly had so much to contribute to our understanding of this medical activity that it warranted a shift in our focus from medical lobbying *tout court* to medical 'persuasion' more generally.[3] In making this move we also acknowledge recent scholarship which emphasises the contingent nature of the medical contribution to developments in improvements in sanitation and hygiene.[4] However, despite the variability of their success, as we set out below, medical practitioners often sought to influence public health policy across this period. Their contributions, although not necessarily determinative, were often given a privileged position in public debate. Accordingly, in examining the art of medical persuasion we look not at outcomes – what was the effect on policy of medical contribution – but on the mechanism of that contribution itself. How did doctors strategically approach these debates, in what other arenas did they seek to be persuasive, how did they cultivate their privileged voice, and why was it often granted to them?

History, the Royal Historical Society, the University of Southampton, and the University of Western Australia for funding the original workshop.

[3] For medical perspectives in this area, see the Centre for the History of Emotions at Queen Mary blog, at https://emotionsblog.history.qmul.ac.uk/. For recent works of medical history that engage with the history of emotion, see Joanna Bourke, *The Story of Pain: from pain to painkillers,* (Oxford, 2014) and Michael Brown, 'Surgery and Emotion: the era before anesthesia', in Thomas Shclich (ed.), *The Palgrave Handbook of the History of Surgery*, (Basingstoke, 2017).

[4] See for example, Tom Crook, *Governing systems: modernity and the making of public health in England, 1830-1910*, (Oakland, CA, 2016); Graham Mooney, *Intrusive interventions: public health, domestic space and infectious disease surveillance in England, 1840-1914*, (Rochester NY, 2015).

Accordingly, papers in this volume examine factors such as medical practitioners' choice of rhetorical strategy when attempting to persuade. Unlike the scholarship that locates a rhetorical component in doctors' attempts to build effective relations with, and thereby authority over patients the focus here tends to be on the cultural and other contexts outside the clinic in which medical voices were shaped and heard.[5] Indeed, all contributions bar one move outside the therapeutic realm to interrogate the public forums in which such strategies were applied. Several papers examine the exercise of persuasive techniques in the courtroom where important claims to expertise were made that extended beyond the trial and influenced public opinion of medical trustworthiness and expertise generally.[6]

This volume shows that medical professionals developed shared vocabularies of concern across overlapping networks of interest, which were crucial to their attempts to persuade established elites on a range of issues concerning the value of medical expertise, public health, and the regulation of their own profession. In the process of exploring the social, political and cultural elements of medical persuasion, we aim to historicise the construction of medical expertise and thereby to understand more deeply how the leverage of medical knowledge operated and evolved across this period. In knitting specific instances of medical lobbying into broader cultural themes, we aim to integrate histories of medicine and law with more familiar national and cultural histories. Although doctors have been at the art of persuasion for a long time, we focus on the period since the professionalization of

[5] For a discussion of rhetorical strategies that centres on the therapeutic relationship, see David Harley, 'Rhetoric and the social construction of sickness and healing', *Social History of Medicine*, vol. 15, 1999, esp. pp. 414ff.

[6] For the history of medicine and expert evidence more generally, see Tal Golan, 'Revisiting the history of scientific expert testimony', *Brooklyn Law Review*, 73/3 (2007-2008); Carol A. G. Jones, *Expert witnesses: science, medicine and the practice of law*, (Oxford, 1994).

medicine. In encompassing episodes drawn from different national contexts, we also hope to illuminate the various transnational dimensions – cross-cultural and imperialist – that shaped how medical expertise was conceived and harnessed for wider purposes in this era. The distinct dynamics of medical practice and medical politics in parts of the British and French colonial worlds are explained by Aaron Graham and Charlotte Legg in their papers on early nineteenth-century Jamaica and late nineteenth-century Algeria respectively. By including contributions on parts of the British and French empires in this way, we are able to extend the treatment of our theme beyond Western Europe, which nonetheless remains the focus of our attention in the volume.[7]

Historiography and context

As suggested above, the nineteenth century was something of a fulcrum for the creation of the politically active physician. Medical voices were often raised on issues concerning public

[7] Reflecting the prominent position of Scottish doctors in the British Empire, and the importance of the Scottish enlightenment to medical history of this period, two papers in this volume focus on case studies of persuasion in Edinburgh. For a very recent discussion of the significance of the Scottish Enlightenment see Catherine Jones, 'Collectors of natural knowledge: the Edinburgh Medical Society and the associational culture of Scotland and the North Atlantic world in the 18th Century ', J R Coll Physicians Edinb 2018; 48: 155–64; there is a vast body of scholarship on this point but generally see L.S. Jacyna, *Philosophic Whigs: medicine, science and citizenship in Edinburgh 1789-1848,* (Routledge, 1994); and M. Ackroyd, L. Brockliss, M. Moss, K. Retford and J. Stevenson, *Advancing with the Army, Medicine, the Professions, and Social Mobility in the British Isles, 1790–1850* (Oxford: Oxford University Press, 2006)

health and the regulation of medicine. In Britain, the forerunner to the British Medical Association was founded in 1832 as a professional interest group for medical doctors, and by the middle decades of the century it played an active role not only in the regulation of the practice of medicine, via the Medical Act of 1858, but in the increased parliamentary activity in the growing field of public health.[8] Although not a direct comparator, the French Academy of Medicine was founded in 1820, the fruit of post-revolutionary power struggles among medical bodies and the Restoration monarchy's desire for a 'pliable instrument of state policy'.[9] Never intended as an institution to represent all physicians, its engagement in parliamentary activity was extensive, in part for its role in authorizing new remedies and therapeutic mineral springs, but mainly because its remit was to advise the government on public health issues. The scientific and therapeutic worlds of medicine thus frequently intersected in this period with those of law-making and policy-enacting state bureaucracy.

We also know that in some times and places, the dividing line between medical and political actors was quite porous. Under the French Third Republic (1870-1940), for instance,

[8] For the history and evolving remit of the association, see Harry Eckstein, *Pressure group politics: the case of the British Medical Association*, (London, 1960).

[9] See George Weisz, *The Medical mandarins: the French Academy of Medicine in the nineteenth and early twentieth centuries*, (Oxford, 1995), p. 26. On the institutional dynamics of French medicine in this period as well as the extension of medical concerns into cultural and political domains, see the various contributions to Ann La Berge and Mordechai Feingold, (eds.), *French medical culture in the nineteenth century*, (Amsterdam, 1994). It is interesting to note the comparative lack of professional organisation among medical doctors in nineteenth-century Prussia, where the state had long controlled medical education and entry into the profession, to the extent that physicians had been reduced to the status of civil servant. See Claudia Huerkamp, 'The Making of the modern medical profession, 1800-1914: Prussian doctors in the nineteenth century', in Geoffrey Cocks and Konrad H. Jarausch, (eds.), *German Professions, 1800-1950*, (Oxford: Oxford University Press, 1990), pp. 66-83.

physicians comprised the second largest professional group after lawyers within the French parliament (Chamber of Deputies). According to the foundational work on this subject by Jack Ellis, in applying their medical expertise to problems of social reform, these so-called 'physician-legislators' contributed to the development of both legislation and government policy in the realm of public health. One prominent example is Dr Théophile Roussel, also a member of the Academy of Medicine, who led parliamentary bills designed to curtail alcoholism (through policing public drunkenness) and to improve infant welfare (in particular through the regulation of wet nursing in the 1870s). 'Physician-legislators' also made their mark in the world of factory hygiene, for instance in the crusade against lead paint; in providing clean drinking water, facilitating cremation and meat inspections; in fighting typhoid, small pox, cholera, tuberculosis; extending inoculation; and eradicating fraudulent milk products like margarine.[10] Dr Paul Brouardel, another member of the Academy of Medicine and dean of the Paris Faculty of Medicine, presided over the Consultative Committee of Public Hygiene in the late nineteenth century. According to George Weisz, he played a key role in shaping public health in France precisely because 'he bridged the worlds of the Parisian medical elite, the public health bureaucracy, and national politics'.[11] By contrast, only a handful of medical doctors sat in the House of Commons in Britain in the decades before the First World War, but as Roger Cooter has shown, that did not mean that physicians did not seek election nor that they failed to achieve parliamentary influence in the early decades of the twentieth century.[12]

[10] Jack D. Ellis, *The Physician-legislators of France: medicine and politics in the early Third Republic, 1870-1914,* (Cambridge, 1990).

[11] Weisz, *The Medical mandarins,* pp. xiii, 79.

[12] Roger Cooter, 'The Rise and decline of the medical member: doctors and parliament in Edwardian and interwar Britain', *Bulletin of the History of Medicine,* vol. 78, 2004, pp. 59-107. Cooter counted 159 medical

The intersection between medical and political agency proved so enduring in part because it was enabled by the new institutionalized structures within medicine. It was also made possible by the growing challenges governments faced in terms of managing disease. A rich seam of monographs and articles has explored the process by which 'public health' accordingly came into being in this period, and the place of medical professionals within it.[13] The spread of disease, manifested most obviously in the outbreaks of plague, yellow fever and cholera that characterized the early to mid-nineteenth century, meant that nation states were forced to debate the merits of various policies to contain it. In this, medical disagreement became implicated in political divisions over how best to combat epidemics without damaging trade. That was especially the case in the 1810s-1820s when the opposition of 'contagionists' (who believed any given disease was transmitted by contact) and 'anticontagionists' (who believed disease to be communicated or generated in other ways)

practitioners who stood for election between 1918 and 1945, with 72 successfully elected, p. 61. He also makes the point that before the creation of the National Health Service in the 1940s it was local councils that took the initiative in health policy, not the state, rendering the British 'physician-legislator' a less significant actor, p. 62.

[13] Ann Elizabeth Fowler La Berge, *Mission and method: the early nineteenth-century French public health movement,* (Cambridge, 1992); L.S. Jacyna, *Philosophic Whigs: medicine, science and citizenship in Edinburgh 1789-1848,* (Routledge, 1994); Margaret Pelling, *Cholera, fever and English medicine 1825-1865,* (Oxford, 1978); C. Hamlin, *Public Health and Social Justice in the Age of Chadwick, Britain, 1800-1854* (Cambridge, 1998). More recently, Michael J.D. Roberts, 'The Politics of professionalization: MPs, medical men, and the 1858 Medical Act', *Medical History,* 2009, 53: 37-56. Also, Crook, *Governing systems.* On Germany, see Manfred Berg and Geoffrey Cocks (eds.), *Medicine and modernity: public health and medical care in nineteenth- and twentieth-century Germany,* (Cambridge: Cambridge University Press, 1997).

fuelled parliamentary debates about the wisdom of the quarantine of ships where such diseases were known on board.[14]

Increasingly, it was questions of clean water supply in the growing industrialised urban centres of Europe, as well as debates over vaccination against smallpox that prompted such medico-political interventions. All of this signals the involvement of the medical profession not only in the parliamentary realm, but firmly among those interested in addressing the 'social question' of poverty and squalor caused by industrialisation. The results included the British Public Health Act 1848 and the Vaccination Act of 1853.[15] In France, one can point to over two dozen laws regulating public health or medical reform that were influenced by 'physician-legislators' between the 1870s and 1914.[16] Thus, the physician lobbyist, working closely with and sometimes even within parliamentary structures was a recognised figure in Britain and France, and in their colonial centres by the end of the nineteenth century. It is important not to overemphasise the influence of medical practitioners

[14] On the British debates about quarantine and contagion, see Catherine Kelly, '"Not from the college, but through the public and the legislature": Charles Maclean and the relocation of medical debate in the early nineteenth century', *Bulletin of the History of Medicine,* vol. 82, no. 3, 2008; E.H. Ackerknecht, ''Anticontagionism between 1821 and 1867', *Bulletin of the History of Medicine,* vol. 22, (1948); M. Pelling, *Cholera, Fever and English Medicine 1825-1865*; R. Cooter, 'Anticontagionism and History's Medical Record', in P. Wright and A. Treacher (eds.), *The Problem of Medical Knowledge* (Edinburgh, 1982); P. Baldwin, *Contagion and the State 1830-1930* (Cambridge, 1999). For the French case, see La Berge, *Mission and method*; and E.A. Heaman, 'The Rise and Fall of Anticontagionism in France', *Canadian Bulletin of Medical History*, vol. 12, 1995).

[15] See Simon Szreter, 'The GRO and the public health movement in Britain, 1837-1914', *Social History of Medicine,* 1991, pp. 435-463.

[16] Ellis, *The Physician-legislators of France,* Appendix B, pp. 248-9, lists the 28 laws created where physicians in either the Chamber of Deputies or Senate had served as influential committee reporters between 1871 and 1914.

in the development of public health, however it is very clear that medical doctors took significant initiative and were prominent voices among the myriad actors in this space. [17]

In addition to facilitating this overt engagement with governmental and parliamentary authorities, medical institutions such as the BMA and Academy of Medicine, as well as the educational institutions in which physicians and surgeons were trained played a role in shaping what it meant to be a medical professional. On one level, that is because doctors organised to reform medical education itself through their lobbying efforts, seeking to guarantee the status and financial reward of the profession by restricting entry to it. In Britain, the key moment was the Medical Act of 1858. Its creation of the General Medical Council led to the registration of all physicians and surgeons, thus defining what constituted lawful medical practice and creating constraints on entry into the profession.[18] As Aaron Graham demonstrates in his discussion of medical politics in Jamaica in this volume, similar professional associations and regulatory bargains were struck in Britain's colonies.[19]

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[17] See for example, Crook, *Governing systems*; Mooney, *Intrusive interventions.*

[18] For a discussion of the political strategies used by medical practitioners to influence this regulatory bargain with the State see Roberts, 'The Politics of professionalization'. For discussion of the professionalizing project of medical practitioners (especially general practitioners) in this period see I. Loudon, *Medical Care and the General Practitioner, 1750-1850*, (Oxford, 1986); A. Digby, *The Evolution of British General Practice, 1850-1948*, (Oxford, 1999); see also T. Gelfand, *Professionalizing Modern Medicine: Paris Surgeons and Medical Science and Institutions in the eighteenth century* (Connecticut, 1980).

[19] Developments in medical registration laws in colonial and non-European contexts are largely dealt with in single article case studies such as those of Roberts and Legg in this volume, other examples include: M. Lewis & R. MacLeod, 'Medical politics and the professionalisation of medicine in New South Wales, 1850–1901' 1988 Journal of Australian Studies, vol. 12, no. 22 (1988); P. Yunjae, 'Medical Policies toward Indigenous Medicine in Colonial Korea and India' *Korea Journal*, 2006. Some discussion of the legal and regulatory developments in comparative jurisdictions can be found in: T.N. Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany and the United States, 1750-1945* (Oxford, 1995).

By comparison, the standard requirement for lawful practice in France was already the state-regulated medical degree, so the quest for status there took a different form. Medical professionals' long-running efforts triumphed in the law passed in 1892 that axed the lesser role of *officier de santé.* The 'health officer', introduced during the revolutionary and Napoleonic period in part to make up for a shortage of trained doctors in a time of constant war, was later reviled by fully trained physicians as a source of medical competition.[20] The 1892 law also regulated the practice of foreign doctors, legalised medical unions, and criminalized unsanctioned medical practice.[21] By the mid-1930s professional medical organizations in tandem with key physician-legislators achieved further constraints on the admission of foreign students onto medical degree programmes, and on how quickly naturalized doctors could practise. This latter example shows how debates about entry into the profession were entwined with xenophobia, and indeed anti-Semitism.[22] As Charlotte Legg explains in her contribution to this volume, the situation in colonial Algeria, a vast territory notionally administered as part of France after the late nineteenth century, debates over regulating practice were further complicated by under-resourcing, ethnicity and religion. There, 'native' Muslim doctors petitioned the French authorities for formal recognition vis-à-vis their European settler physician counterparts. Their efforts were rewarded by the creation of the Indigenous Medical Auxiliary Corps in 1904 into which 'native' practitioners were integrated, if on distinctly inferior terms.

[20] Robert Heller, '*Officiers de santé*: the second-class doctors of nineteenth-century France', *Medical History*, vol. 22, 1978, pp. 25-43.

[21] George Weisz, 'The Politics of medical professionalization in France, 1845-1848', *Journal of Social History*, 12, 1, 1978, pp. 3-30; Ellis, *The Physician-legislators of France*, pp. 149-56.

[22] Julie Fette, *Exclusions: practicing prejudice in French law and medicine, 1920-1945*, (Ithaca, 2012), Chapters 2 and 3, pp. 30-89.

On another level, medical institutions played a role in teaching fledgling doctors how to behave as professionals, communicating both consciously and inadvertently the social and cultural content of professional success.[23] Physicians had to learn how to communicate with a wide range of social demographics, since their livelihoods in general practice depended on the payment of patient fees. Projecting authority across a wide register was especially important because establishing oneself in the profession was by no means guaranteed: the environment in which medical students sought to build a general practice or acquire a hospital position was a competitive one in Europe, not just in mainland Britain and France, but in much of Germany across the long nineteenth century, too.[24] It is by paying attention to institutionalised influences that we can come closer to understanding how members of the medical profession accumulated the kind of cultural influence that is likely to have made them effective lobbyers of their own or others' interests. In this sense, the cultural work that a certain kind of professional status performed need not be thought of as separate from the

[23] For a detailed and multi-dimensional account of the life of medical students and the nature of medical training, see Florent Palluault, 'Medical students in England and France, 1815-1858: a comparative study', DPhil, University of Oxford, 2003. See also for discussion of medical students and acculturation in various contexts: L. Rosner, *Medical Education in the Age of Improvement: Edinburgh Students and Apprentices, 1760-1826*, (Edinburgh, 1991); Keir Waddington, *Medical education at St Bartholomew's Hospital 1123-1995*, (Woodbridge, 2003); Laura Kelly, *Irish Medical Education and Student Culture c. 1850-1950*, (Liverpool, 2017).

[24] For Britain, see Penelope J. Corfield, *Power and the professions in Britain, 1700-1850*, (London and New York, 1995), Ch. 6, 'Doctors', pp. 137-173. For France, see the rather anecdotal Pierre Darmon, *La Vie quotidienne du médecin parisien en 1900*, (Paris, 1988). Professional overcrowding was a concern of medical doctors in Prussia, as it was elsewhere. See Huerkamp, 'The Making of the modern medical profession', pp. 76-77.

deliberate and pointed engagement with parliamentary processes in which medical doctors participated, but rather as a prerequisite for it.

If medical doctors organised to control entry into their profession and to influence state action in the growing sphere of public health over the long nineteenth century, they also mobilised against state incursions into their professional autonomy. This was probably most marked in the newly unified Germany, where Otto von Bismarck had established a system of sickness funds in the early 1880s, offering a measure of socialised health care to workers. The new system, however, threatened the professional autonomy of doctors, not to mention their fee income in an era of professional overcrowding. By 1900 a Union of German Physicians for the Defence of their Economic Interests had formed. This so-called 'LV', later known as the Hartmannbund proved remarkably successful in the early twentieth century both in mobilising physicians as members, and in using the tactics of trade unions (notably strikes) to win important concessions.[25] Yet the defence of a particular model of professional sovereignty—based on doctor-patient confidentiality, free patient choice of doctor, direct payment to the physician of a fee, and freedom of doctors to diagnose and prescribe—proved to be much more widespread.[26] In France and the U.S.A., for instance, such principles were routinely mobilised by medical organisations when faced in the interwar years with the prospect of compulsory health insurance rolled out by state governments eager to oversee some measure of health care provision for parts or all of the population. The potential involvement of third parties like mutual aid societies or insurance companies in such

[25] For a succinct overview, see Donald W. Light, Stephan Liebfried and Florian Tennstedt, 'Social medicine vs professional dominance: the German experience', *American Journal of Public Health*, January 1986, vol. 76, pp. 78-83; Huerkamp, 'The Making of the modern medical profession', pp. 77-80.

[26] Paul V. Dutton, *Differential diagnoses: a comparative history of health care problems and solutions in the United States and France*, (Ithaca: Cornell University Press, 2009), pp. 31-32.

schemes, in addition to the moves of the state itself posed a direct threat to physicians' interests while also providing employment for them. The professional dynamics in play took a distinctive course within each national context, and they helped to produce different outcomes depending on where one looks.[27]

These institutionalized structures of professional mobilisation and self-regulation, political intervention and medical education (in both a technical and wider sense) endured well into the twentieth century. Indeed, one must be careful not to overstate the apparent rupture of 1945, when in the aftermath of war more fully nationalized systems of social security, including health care were created in much of Western Europe—although pointedly not in the United States.[28] As the examples above illustrate, the work of health insurance funds, especially in Germany and France had brought employers, mutual aid societies, trades unions and the public powers into a formal relationship for decades already, and conversely French doctors managed to retain key principles of private practice. It is the British National Health Service founded in 1948 that appears to represent the most significant break with the past, since the extension of the state's power into the domain of private-practice medicine was most successful there.[29] Yet even under the post-war British model, the state did not

[27] Dutton, *Differential diagnoses*, Chapters 2-5.

[28] The situation was fundamentally different in the United States of America, where resistance to compulsory health insurance never mind fully socialized medicine remained strong. See Paul V. Dutton, *Differential Diagnoses: a comparative history of health care problems and solutions in the United States and France*, (Ithaca: Cornell University Press, 2007), Chapter 5.

[29] For an overview of the mixed system of insurance-based and private medicine in Britain in the earlier decades of the twentieth century after the introduction of the National Insurance Act of 1911, see Anne Digby and Nick Bosanquet, 'Doctors and patients in an era of national health insurance and private practice, 1913-1938', *Economic History Review*, vol. 41, no. 1 (Feb. 1988), pp. 74-94. For an interesting discussion of how an interwar novel about medical doctors seemed to tap into public dissatisfaction with health care, see Ross

wield absolute power over doctors, and over time it involved third parties as well. As Susan Giaimo reminds us, we should speak of 'systems of social protection' rather than the 'welfare state' precisely to allow for the mediating roles played by insurance and pension funds as well as other private-sector bodies in sustaining whatever social contract a state puts in place through legislation.[30]

In other words, we should not allow the undeniable shifts of the immediate post-war medical landscape to obscure either national variations in medical provision or the thematic continuities that prevailed. One constant was the quest for professional security and professional advantage itself, however much such things continued to be inflected by specific contexts. Recognising the contours of the professional stakes attendant upon the actions of medical doctors outside the clinic helps us to understand why they became involved in (often very) public efforts of persuasion in the first place. In terms of the questions that most preoccupy this volume, medical doctors still engaged with public authorities on a range of public health matters, and were often drafted into public health campaigns in the later decades of the century, including those that aired on new technologies such as television.[31]

McKibbin, 'Politics and the medical hero: A.J. Cronin's *The Citadel'*, *English Historical Review,* vol. Cxxiii, no. 502, pp. 652-678.

[30] Susan Giaimo, *Markets and medicine: the politics of health care reform in Britain, Germany, and the United States,* (University of Michigan Press, 2009), p. 7. In order further to highlight the complexities of state provision of health in the later twentieth- and twenty-first centuries, Giaimo draws on a model that delineates three distinct ideal-types of welfare state regimes – the social democratic (for which Britain is the best exemplar), the corporatist (Germany) and the liberal (U.S.A.), p. 5.

[31] For comparative studies of post-1945 health care systems, which also examine the relationship between medical and policy agency, see David Wilsford, *Doctors and the state: the politics of health care in France and the United States,* (North Carolina, 2002), Melanie Latham, *Regulating reproduction: a century of conflict in*

They still sought to appeal to a wide public audience, whether in relation to their on-going lobbying work aimed at changing public policy in health matters or in more diffuse ways, such as through the writing and publication of books for a popular market. And it was still necessary for them to harness the full range of their social and cultural, as well as their technical medical expertise in making themselves understood in all of these endeavours.

Themes in this volume

In seeking to understand the persuasive techniques cultivated by medical practitioners, the papers collected in this volume explore the engagement of doctors with public health but also with topics outside that well-trodden ground. One of the most striking themes to emerge from these essays is that medical practitioners ventured far from their consulting rooms and hospitals to practise the art of persuasion. Key sites of activity included the courts, the popular press, public spaces both tangible and intangible, and legislative chambers. The topics on which they sought to influence opinion varied across a wide spectrum. In so doing, many had to first establish their credentials or expert status to speak on those issues, and so their own expertise often became the first issue on which they needed to shape opinion.

Predictably, one of the most powerful arguments available to medical practitioners in doing so was their expert knowledge. Then, as now, the question of who was and was not expert on any particular topic was not straightforward. As we can see in Michael Brown's examination of a dispute between practitioners in Edinburgh, and in Charlotte Legg's article detailing competition between European settler and 'native' practitioners of colonial medicine in Algeria, competing claims to expertise among medical practitioners was a prominent feature of many debates. Amidst controversy over which forms of medical

Britain and France, (Manchester, 2002), and Constance A. Nathanson, *Disease prevention as social change: the state, society, and public health in the US, France, Great Britain and Canada,* (New York, 2009).

education and medical philosophy were paramount, some ways of knowing became privileged in public discourse. Victoria Bates describes how the cultural value of statistics increased significantly in the nineteenth century alongside the emergence of the statistical sciences and the rise of mass data collection. The usefulness of these sciences to medical practitioners in seeking to understand disease, and to propel their professional standing has been noted by medical historians of this period, including most notably Ulrich Trohler in his classic text *To Improve the evidence of medicine*.[32] Feeding into a climate of 'rational empiricism', medical practitioners found the new science of 'medical arithmetic' had the appearance of compelling expertise combined with the cold objectivity of a weight of numbers. Those skilled in interpreting and deploying the findings of this data could gain a significant persuasive advantage. In the following articles, Aaron Graham, Michael Hau, and Victoria Bates all examine the efforts of medical practitioners to wrangle with statistical evidence in order to support their advocacy of particular public health measures. As Graham notes, public health advocacy was (and is) essentially a political exercise and as such, the claims of these doctors were inevitably examined and contested by competing non-medical interests. Read together, these papers reveal the significance of statistical evidence to medical practitioners themselves, and how useful that data could be to them in gaining traction on public health issues. However, the papers also highlight how the expert and nuanced

[32] Ulrich Trohler, *To Improve the evidence of medicine: the 18th-century origins of a critical approach*, (Edinburgh, 2000). See also M. Poovey, *A History of the Modern Fact: Problems of Knowledge in the Sciences of Wealth and Society* (Chicago, 1998); G. Jorland, A. Opinel, G. Weisz (eds), *Body counts: medical quantification in historical and sociological perspectives/ La Quantification médicale, perspectives historiques et sociologiques* (Montreal and London, 2005).

understanding medical experts brought to the analysis of data could be an unwieldy, ineffective, and sometimes counter-productive tool, when evidence filtered through the popular press either overstimulated public imagination (Bates) or when medical data about the consequences of alcohol abuse presented by physicians was reframed (or manipulated) by the alcohol lobby to suggest the harmlessness of alcohol consumption (Hau).

The intervention of the media discussed so effectively by Hau and Bates highlights another important theme of this collection – that the success of a persuasive technique lay not just in how it was delivered, but also in how it was heard. Even when using the 'cold' devices of statistics and science, effective medical persuaders demonstrated a self-consciousness about language. This awareness extended beyond the use of complex statistics and also encompassed the more traditional medical ways of knowing, an understanding of the body and of disease. In many of the case studies presented by our authors we can see deliberate and thoughtful attempts by medical practitioners to modify their language for different lay audiences. We can see this clearly when doctors entered the courtroom as expert witnesses: Kelly Ann Couzens demonstrates how doctors learning the art of forensic medicine in the 1830s were taught that for medical testimony to be persuasive 'doctors had to embrace terminology and practices outside the strictly medical sphere'; and more recently, Victoria Bates details the disproportionate impact of a medical witness' use of a horse-racing analogy to explain the probability of three infant deaths in one family. In the political sphere Aaron Graham shows how medical practitioners in Jamaica adapted their argument, removing a radical social justice rhetoric, which, while successful in London on the same issue, was not socially or politically palatable in Jamaica.

Further, ways of speaking, of affecting sensibilities and cultural refinements, were just as important as choice of language in the packaging of public health messages. Alison Moulds and Joan Tumblety explore the importance of being attuned to social conventions for

doctors, whether they were seeking to persuade patients of their professional authority in the surgery itself, or attempting to reach wider audiences with their ideas about healthy living. What was required was a form of cultural competence. Tumblety shows how important for the entrepreneurial physician at the centre of her essay was proficiency across a range of different genres of writing and performance. Cumulatively, these pieces show that medical practitioners thought carefully about how to speak to different audiences, whether they were seeking to enhance their market or cultural reach, to adapt to their political environment, to influence a jury of non-experts, to persuade their peers, or as Michael Brown demonstrates, to delve into the emotional spaces of public and private imaginations. What emerges for our enquiry as important is that in seeking to be persuasive medical practitioners self-consciously deployed a mercurial voice. They did not rely solely, as might be expected, on a static and professionally constructed register that leveraged only their obvious persuasive advantage - medical expertise and knowledge. They had to adapt the tone, style and content of their words for each new context or audience.

In contrast to the need for a changeable voice and vernacular, medical practitioners believed that in order to be heard they had to embody a very precise physical image that maintained a 'medical otherness' that was not adapted from audience to audience. As the following papers demonstrate, across these centuries the medical practitioner was hyper-conscious of techniques of non-verbal performative persuasion, which relied strongly upon an idealised medical persona. Christopher Lawrence has pointed to the convergence of medical and surgical self-representation around particular characteristics including, most significantly, physical attributes and affectations signifying the ideals of gentlemanly identity

in the nineteenth and early twentieth centuries.[33] Similarly, others have pointed to the importance of appealing to gentlemanly forms in the cultivation of patients and social respectability.[34]

In the context of persuading lay audiences of medical expertise, the articles written by Kelly Ann Couzens and Alison Moulds reinforce the findings of those historians, and examine closely the views of medical practitioners on the importance of physical image and self-representation. Both focus on the advice imparted by senior established figures to young practitioners embarking on their careers. In the explicitly adversarial environment of the courtroom, Couzen's investigates the formal education given to young practitioners contemplating the giving of expert forensic evidence. Purveying a 'new science' that faced some incredulity from established actors in the legal system and from juries, medical witnesses encountered an environment in which persuasion was essential. As Couzens describes, before practitioners were likely to have the merits of their evidence taken seriously, they were advised to hone key weapons in their arsenal including a focussed and serious appearance, well-modulated voice and confident manner. Practitioners who went into the courtroom unprepared, or ill-equipped in these ways would find that in not being seen as persuasive, they could not be heard. Moulds investigates how a range of texts aimed at young practitioners recommended strategies to help them persuade patients and colleagues of their legitimacy. Appearances were important, and young practitioners were advised to cultivate restrained external signifiers of status and sobriety in their dress and consulting rooms. Even

[33] Christopher Lawrence, 'Medical minds, surgical bodies: corporeality and the doctors' in Christopher Lawrence and Steven Shapin (eds.), *Science incarnate: historical embodiments of natural knowledge*, (Chicago, 1988), pp. 156-201.

[34] Ludmilla Jordanova, *Defining features: medical and scientific portraits, 1600-2000* (London, 2000); Lisa Rosner, *The Most beautiful man in existence: the scandalous life of Alexander Lessassier* (Philadelphia, 1999).

more significant was the observance of medical etiquette with both patients and other practitioners. This was an important route to achieving professional acceptance. Moulds argues that conspicuous conformity to these standards was moreover crucial for the profession, which needed to demonstrate a shared value system as it endeavoured to persuade the public that it was a responsible and respectable self-regulator following the Medical Act of 1858.

The need to project a particular appearance or character can also be discerned in the writing persona adopted by practitioners seeking to persuade reading audiences. In each of the articles written by Joan Tumblety, Charlotte Legg, and Michael Brown, the authorial persona assumed by medical writers is considered in different contexts. Common to all however, is the goal of persuading targeted audiences that the writer is more expert than others. These pieces demonstrate that it was important to project a certain character as an author that was a reflection of how a serious medical practitioner should appear: refined and scientific both. Interestingly, Brown's article turns in examining the various personal characteristics performed by two competing medical writers, including humour, to evaluate which was able to win over the public audience. In the course of debate one writer acknowledges and denounces the 'performative stamp' and external trappings required of 'the successful doctor' during the nineteenth century. Yet despite his attempts to cast aside appearance and performance in the pursuit of successful persuasion, his adversary—the medical practitioner who conformed to and personified the expected role of 'doctor'—won the public and professional debate.

What emerges from these articles is that in performing expertise, in seeking to become persuasive, medical practitioners across the nineteenth and early twentieth centuries leaned in to established stereotypes that were cultural signifiers of expertise, refinement and (where relevant) rationality. They were consciously aware of and reinforced these

performative roles to junior professionals in advice imparted through both books and lectures. In modelling and endorsing the importance of these characteristics medical practitioners reinforced the cultural norms that dictated what sort of person, or type of man more specifically, would be considered sufficiently trustworthy and professional to be believed. Conversely, Jane O'Neill shows that doctors' attitudes to patients were also shaped by such norms, in her examination of the strategies that women deployed in order to convince their doctors to allow them a termination under the Abortion Act 1967. Majoring on the therapeutic space of the clinic itself, O'Neill describes the 'doctor/patient games' that took place in GP surgeries, in which both physicians and their pregnant patients recognised that a conception presented as 'bad luck rather than bad behaviour' made a more compelling—because more morally 'deserving'—case for termination.

Each paper in this volume carefully dissects the pre-meditated persuasive strategy adopted by medical practitioners either individually or collectively to achieve a variety of ends. It is evident from the whole that to be successful a careful balance was required: medical practitioners had to project either in person or in print a character that conformed with public expectation of an 'other', a scientific and rational gentleman. However, the words actually spoken or written – the voice used – required modulation. Medical expertise, once established by performance, had to be massaged and packaged for the right audience. These considerations might be coloured by perceived acceptable politics, imagined day-to-day vernacular, or 'relatable' metaphor. In many instances considered here, doctors are at pains to transmit their insight about these points to young doctors beginning their careers. The collective self-awareness the profession exhibited about what was required to be persuasive must lead us to ask how significant this aspect of professional practice was in shaping professional identities in medicine and the character of the medical profession more generally. Not all doctors were lobbyists, and many medical lobbyists were unsuccessful. But

many doctors sought and still seek to be persuasive advocates within communities, beyond the intimate relationship of individual doctor and patient. Accordingly, we must consider that the professional identity of medical practitioners includes and is partially shaped by the need to be persuasive, and by the dictates of personal appearance and use of language that medical persuasion necessitated.