This paper is the second of two essays devoted to a sociological examination of the emergence and attempted professionalization of psychiatry in Victorian England. The late eighteenth and early nineteenth centuries witnessed the rapid growth of an institutional response to madness: first in the form of private, profit-making madhouses, and then, via direct state investment in the asylum solution, in the form of a rapidly proliferating network of county asylums coping with the ‘pauper insane’. The development and consolidation of these institutional means of coping with madness parallels that of a group of ‘experts’ in the management of the mad. For it was the existence of institutions which permitted, or perhaps it might be more accurate to say, formed the breeding ground, for this emerging coterie of specialists. During the nineteenth century, at least, ‘psychiatry’ is to all intents and purposes coextensive with ‘institutional psychiatry’.

Sociologically speaking, one may view the attempted professionalization of psychiatry as involving two basic processes: the capture—even to some extent the creation—and the organization of a particular service market along monopolistic lines; and the attempt to secure for those practicing this line of work certain status prerogatives, most particularly autonomous control by the practitioners themselves over

- The first one in AES, XVI (1975), 218-261.

Arch. europ. sociol., XVII (1976), 279-303
the conditions and conduct of their work. In an earlier essay on this subject (1), I demonstrated how the so-called ‘mad-doctors’ manœuvred to secure a cognitive and practical monopoly over the management of the distracted, in the process transforming madness into mental illness. The analysis presented here builds on that earlier paper, and examines how mad-doctors in the second half of the nineteenth century were able to retain and make use of their monopoly; and the extent to which they were able to secure for themselves the other trappings of professional status.

By 1845 the medical profession had secured elite support for the proposition that insanity was a disease, and thus was naturally something which doctors alone were qualified to treat. Medicine’s claims had received statutory endorsement in legal requirements which gave it a protected, quasi-monopolistic position in the field, largely through its control of the only legitimate institutions for the treatment of the insane. For the rest of the century, the asylum doctors were primarily preoccupied with consolidating their position, being particularly concerned to develop and secure a large measure of professional autonomy.

One of the first moves towards the establishment of a distinct identity for this new group of ‘experts’ was the creation of their own professional organization, the Association of Medical Officers of Asylums and Hospitals for the Insane. Founded in 1841, the Association drew its membership from the medical staff of both public and private asylums, a situation which hampered moves to unify the profession and, for much of the nineteenth century, diminished the organization’s effectiveness (2). Temporarily, at least, the Association was further weakened as a weapon in the professionalization process by its failure to publish its own journal—no one being willing to assume the position of editor (3). This meant that contacts among the membership were effectively limited to those provided by a single conference once a year. When the first English periodical wholly devoted to the treatment of insanity as a medical speciality appeared in 1848, it was published completely independently of the Association. Owned and edited by Dr. Forbes Winslow, the proprietor of two Metropolitan Licensed Houses, the Journal of Psychological Medicine and Mental Pathology not surprisingly exhibited an editorial bias in favor of private asylums (4). But it was the public sector which

was expanding most rapidly by now, and the county asylum superintendents were obtaining a dominant position in the Association. And in 1853, the society commenced publication of its own periodical, the *Asylum Journal*, under the editorship of John Bucknill of the Devon County Asylum (5). ‘Any profession bases its claim for its position on the possession of a skill so esoteric or complex that non-members of the profession cannot perform the work safely or satisfactorily and cannot even evaluate the work properly’ (6). Herein lay much of the significance of the appearance of two specialized technical journals on the medical treatment of insanity. For their existence, when coupled with the large number of monographs on the subject which had been published over the previous twenty or thirty years, made it difficult for outsiders to avoid concluding that considerable expertise had already been developed in handling and treating the insane, and that existing knowledge was in the process of being further refined and extended. Neither journal lost the opportunity to emphasize that “Insanity is purely a disease of the brain. The physician is now the responsible guardian of the lunatic and must ever remain so” (7), a theme which was also prominent in the medical texts which continued to appear on the subject (8).

In the early part of the century, entry into the ranks of asylum superintendents was largely an unstructured process. Even among the medical men entering the field, few could claim to have had any formal training in the care and cure of the insane; though some had presumably attended lectures on the subject given by Cullen or Morison, while others had relatives already in the business, and thus had some practical experience by way of preparation (9). As most county asylums opened after a considerable expansion of the private madhouse system had already taken place, a number recruited their first superintendent from those who had had prior experience in the

(5) Blandford 1879. Initially, the Journal appeared every six weeks. In 1855 its name was changed to the *Asylum Journal of Mental Science*, and it began to appear quarterly. In 1857 it became the *Journal of Mental Science*, and it is now the *British Journal of Psychiatry*.

(6) Friedson 1970 a, p. 45.


(8) E.g., Steward 1945; Crowther 1849; Monro 1850; Noble 1853; Conolly 1956; Bucknill and Tuke 1858; Robinson 1859; Winslow 1854, 1860; Maudsley 1867. The most important of these was Bucknill and Tuke’s *Manual of Psychological Medicine*. Intended ‘as a systematic treatise for the use of students and medical practitioners’, it became the standard text on the subject in both England and America, running through four editions by 1879. Cf. Braceland’s Introduction to the 1968 facsimile edition, p. vii.

(9) E.g., Samuel Glover Bakewell; Francis Willis, Jr.; the Newington family at Tilehurst.
private sector (10). Others simply installed a local doctor who professed an interest in the job (11).

In later years, the recruitment pattern changed somewhat, and the means of entry into the profession became more stable and formalized. This was particularly marked in the case of the county asylums, where the distinctive system generally employed contributed to the development of “an increasingly isolated speciality” (12). As these asylums grew in size, first one, then a number of assistant physicians were employed by each to ease the burden falling on the medical superintendent. The assistants became, in effect, apprentices, superintendents in training, and it was from this pool of experienced men that most senior positions were filled. In some of the largest asylums, a hierarchical structure emerged in the ranks of the assistants, each step up the ladder bringing increased administrative responsibility and less direct contact with patients.

Bucknill and Tuke’s claim that by mid-century “a knowledge of the nature and treatment of Insanity is now expected of every well-educated man” (13) was certainly an exaggeration. Granville was nearer the mark when he asserted that, among most general practitioners of the period, “the lack of acquaintance with lunacy is extraordinary. The great body of medical men appear to know scarcely more of arrangements and method of treatment adopted in asylums than the general public” (14). Nevertheless, at least some of those interested in a career as an asylum doctor managed to obtain limited instruction in asylum methods as part of their normal medical training—most commonly through attendance at a course of ‘Clinical Lectures’ given annually at St. Luke’s Hospital in London. Only a handful of medical students bothered to attend (15). But for all that, the existence of the course allowed at least some of those applying for positions at asylums to claim that they had received some formal training.

(10) E.g., William Ellis came from the Hull Refuge to the Wakefield County Asylum; John Thurnam from the York Retreat to the Wiltshire County Asylum; William Charles Hood from Fiddlington Licensed House to the Colney Hatch County Asylum; and John Millar from Bethnal Green Licensed House to the Bucks County Asylum. However, the traffic was by no means in one direction only. To take only the most prominent examples, William Ellis, Robert Gardiner Hill, John Conolly, and T. O. Frichard all opened private asylums after a period as superintendent or physician of a county asylum.

(11) E.g., Harris at Bedford; Storey at Nottingham; Duck at Cornwall; and Frichard at Northampton.

(12) PARRY-JONES 1972, p. 90.

(13) BUCKNILL and Tuke 1858, p. ix, authors’ preface.

(14) GRANVILLE 1877, vol. I, p. 328. Cf. also the testimony of Browne, Harrington, Tuke, Balfour and Bucknill himself in House of Commons 1877, pp. 78, 93, 117, 151-152, all of whom complain of the ordinary medical man’s ignorance about insanity.

in the speciality; and the asylum authorities themselves promoted this as one of the important “benefits conferred upon the community by the hospital [... ]” (16).

The asylum doctors had initially won acceptance of the idea that insanity was a disease by emphasizing that its origins lay in a physical pathology, and that conventional medical treatment was, at the very least, an important element in its cure; so that only those with medical qualifications could legitimately treat the condition. Any profession, in order for its position “to be secure [... ] must establish its success on knowledge and skill which can only be obtained by becoming a member of the occupation group [... ] Otherwise, it is always possible that people outside the occupation can claim equal or greater skill” (17). By acquiring some of the trappings of a full-fledged profession, and, in particular, by producing public signs of its esoteric skills in the form of an expanded technical literature and a formal course of clinical training, ‘psychiatry’ had moved to safeguard its position against this contingency. Despite this, the notion that insanity was caused by organic lesions of the brain remained a vital prop for the asylum doctors’ contention that it was fundamentally and incontestably a medical problem.

The contrary view that insanity was “a spiritual malady—a functional disease [... ] an affection of the immaterial essence [...] a disorder of the soul and not simply the result of the derangement of the material instrument of the mind interfering with the healthy action of its manifestations [...] naturally led to the conclusion—false in theory and destructive in practice—that for the alleviation and cure of this spiritual malady, spiritual remedies were the most important and essential” (18). Such contentions were “at variance with all a priori and a posteriori reasoning”, and would suggest “the clergyman rather than the physician as the logical person to treat insanity”. They gave “force and longevity to the idea that the administration of physical agents is of little or no avail in the treatment of the disorders of the mind” (19). Yet to the contrary, the best medical knowledge indicated that ‘a system of cerebral pathology’ must be built upon “the physiological principle [...] that mental health is dependent upon the due nutrition, stimulation and repose of the brain; that is, upon the conditions of exhaustion and reparation of its nerve substance being maintained in a healthy and regular state; and that mental disease results from the

(17) FREIDSON 1970 a, p. 10.
(18) WINSLOW 1854, p. 50.
(19) Ibid. pp. 50-51.
interruption or disturbance of these conditions” (20). Those who refused to acknowledge insanity’s somatic basis were chasing “a phantom of the mind—a pathological enigma, having no actual existence apart from the actual imagination which gave it birth” (21).

“The difficulty at the bottom of the question” (22), which all this strong language was designed to finesse, was that no evidence could in fact be produced to show that insanity had a somatic origin. Bucknill and Tuke conceded as much. “A rational pathology must ever be founded upon the basis of physiology [...] In all the organs of the body, except the brain, great advances have been made in the knowledge of their physiological laws [...] But it is quite otherwise with the noble organ which lords it over the rest of the body” (23). Here, the most diligent investigation could produce no positive evidence in support of the somatic hypothesis. Nevertheless, this did not prevent confident assertions being made that “insanity never exists without a physical cause [...] whence it seems to follow that physical agents ought to be resorted to in the first instance, as the means of restoring the healthy and natural state” (24). The public was assured that “daily experience confirms the opinion that Insanity is a disease, and as such, that it is essential that appropriate remedies should be prescribed for each case, and this is the reason why the duties of dispensing medicines have become more onerous” for asylum superintendents (25). As this suggests, a corollary of the consistent efforts to emphasize that insanity was produced by a physical pathology was the widespread predilection or bias among asylum doctors in favor of physical treatment or ‘remedies’. This is not to imply, though, that there was agreement as to the particular treatment to be adopted in any given case, or even as to the value of any one agent in countering mental disturbance, for there was not.

Both the emphasis on the value of conventional medical treatment and the disagreement as to which particular procedures were in fact effective were evident when the Commissioners in Lunacy sought to obtain a representative sampling of professional opinion on the treatment of insanity for their 1847 Report. There was, it is true, nearly unanimous condemnation of the use of massive general blood-letting in cases of mania; but while some condemned local bleeding with

(20) Bucknill and Tuke 1858, p. 342, emphasis in the original.
(21) Winslow 1854, p. 51.
(22) Bucknill and Tuke 1858, p. 341.
(23) Ibid.
(24) Commissioners in Lunacy Annual Report 1847, vol. II, p. 229. This was part of a summary of contemporary medical opinion derived from a questionnaire the Commissioners had sent to all asylum superintendents.
leeches as harmful or useless, many others testified to its great value (26). Emetics and purgatives were endorsed by practically everyone, though with sharp disagreements as to when they should be employed, and wide variations in the degree of enthusiasm displayed. The use of opium had formerly been held to be injurious: “This is now looked upon as prejudice by many of the most experienced physicians”—though not by others—and it was used to calm excited patients (27). The profession was similarly unable to reach a consensus over the treatment of melancholia. “Most of the medical officers who had given us an account of their practices in this form of mental disorder, seem to agree in directing their attention to the state of the alimentary canal, and the organs subservient to the digestive functions, and to be of the opinion that in cases of melancholia the primary cause is to be sought in some derangement there seated” (28). Again, however, there were others who dissented, and who alleged that the problem lay with ‘the vascular system of the brain’ (29). So far as treatment was concerned, some advocated general or topical bleeding, others the free use of opium; more generally, there was stress laid on the value of purgatives. General paralysis and epilepsy were widely regarded as incurable, but where efforts were made to treat cases, recourse was had to ‘the usual physical remedies’. The following is typical: “Dr. Tyerman had tried shaving the head, blisters to the nape or vertex, occasional local depletion, once arteriotomy, calomel followed by purgatives, hot and cold shower baths during severe paroxysms, tonics” (30)—none with particularly happy results (31).

Indeed, it was on the question of results that the asylum doctors’ claims as to the efficacy of medicine proved most difficult to sustain. The enthusiasm of many physicians for the type of remedies they employed against other forms of disease cannot be doubted. At St. Luke’s, for instance, the superintendent boasted that “the average number of curable cases [...] has been during the last year 87; the number of prescriptions dispensed has been 6,846 during the year—a proof that our faith in medicine as a most efficient means of treatment has not been shaken” (32). But the demonstrated inability of a policy of active medical intervention to produce recoveries amounting to more than a fraction of each year’s admissions soon forced a more sober assessment of the value of existing somatic treatments. Little

(27) Ibid. p. 189.
(28) Ibid. p. 204.
(29) Ibid.
(30) Ibid. p. 213.
more than ten years after the establishment of county asylums on a compulsory basis, the publication of what was to be the standard medical text on insanity contained the admission that “in the chronic stages of insanity active remedies are rarely admissible, except to obviate some intercurrent condition, which produces too much disturbance and danger to be permitted to run a natural course and wear itself out. In recent insanity, with symptoms of physical disturbance of little violence and urgency, active medicinal treatment may oftentimes be dispensed with” (33). So that, in what amounted to the overwhelming majority of cases admitted to asylums, it was conceded that “any active medicinal interference is more likely to do harm than good” (34).

For most asylum doctors, the acknowledged failure of this generation of medical treatments to sustain the hopes the profession had originally entertained produced, not an abandonment of their conviction as to medicine’s value in curing insanity, but rather a search for new somatic remedies which would give more plausible substance to the claim. The problem, it was concluded, must lie in the administration of the wrong remedies or of the right remedies in the wrong way, and not in the nature of the undertaking itself (35). In an almost haphazard fashion, a veritable plethora of drugs and medical techniques was enlisted in the battle against insanity. “Hypodermic injections of morphia, the administration of the bromides, cloral hydrate, hypocymine, physotigma, cannabis indica, amyl nitrate, conium, digitalis, ergot, pilocarpine, the application of electricity, the use of the Turkish bath and the wet pack, and other remedies too numerous to mention, have had their strenuous advocates during late years” (36).

“Perhaps the fundamental reason for physical treatments, whatever their later rationale, [was that] without them doctors would have had no lever with which to operate on diseases of the mind [...]” (37). Given the gap between their claims and their capacities, “doctors could not afford not to try anything that was ever reported to have achieved results” (38). Yet although the advocates of conventional medical treatment neglected nothing in their contemporary medical armamentarium, they discovered nothing which worked. Quite clearly: “If the success of the treatment of insanity bore any considerable proportion to the number of remedies which have been brought forward, it would be my easy and agreeable duty to record the triumphs of medicine in

the distressing malady which they are employed to combat. But this, unhappily, is not the case [...] each remedy [...] failing to fulfill all the hopes raised on its first trial” (39). The medical remedies first suggested had proved almost wholly ineffective, and unfortunately “there are no new remedies or modes of relief which can be recommended with confidence” (40). As a practical matter, therefore, asylum superintendents were forced to fall back on their one remaining claim to expertise, their knowledge of moral treatment (which by now meant little more than the efficient management of large numbers of inmates).

All this left the asylum doctors in a distinctly vulnerable position. They had originally gained their monopoly in the treatment of insanity without a knowledge base which would have given them a rationally defensible claim to special expertise in this area; though they had convinced others that they possessed one. Such an assertion was precarious from the outset. As practicing professionals, their inability to produce the cures their alleged expertise should have helped them provide was swiftly evident. And while it was true that, though being the only people with experience in dealing with large masses of ‘crazy’ people in an institutional environment, they perforce developed certain empirically derived skills in managing asylums; yet in the last decades of the nineteenth century, they remained as far as ever from possessing any genuinely scientifically-based knowledge about how to treat and cure the insane. Certainly large claims to expertise and extraordinary insight here rested on a slender foundation. And if “one of the things that marks off professions from occupations is the professions’ claims to schooling in knowledge of an especially esoteric, scientific, or abstract character that is markedly superior to the mere experience of suffering from the illness or of having attempted pragmatically to heal a succession of sufferers from the illness” (41), then at this stage, psychiatry’s status as a profession was likely to be a tenuous and ambiguous one. Assuming that the key dimensions of professional dominance are obtaining and maintaining a monopoly in one’s line of work, and securing freedom from all outside, lay interference (42), I want now to examine the question of whether the

(39) TUKE 1882, p. 485.
(40) GRANVILLE 1877, vol. II, p. 112.
Compare also the evidence of Dr. Lockhart 1877, p. 50.
Robertson before the 1877 Select Committee: (41) FREIDSON 1970 a, Part I and II passim.

‘You are not very strong upon that point?’ A. — ‘No, I am not.’ House of Commons 1877, p. 50.
failure of the asylum doctors' claim to possess special expertise to produce tangible results in the form of cures resulted in serious threats to their monopolistic control of asylums, or to their capacity to sustain a viable degree of professional autonomy (put another way, their ability to declare 'non-expert' intervention presumptively illegitimate).

As I have shown elsewhere (43), by the Acts of 1828 and 1845, the medical profession had acquired a virtually exclusive right to direct the treatment of the insane. Thereafter, its concern became one of maintaining, rather than obtaining, a monopolistic position, a situation where those in possession generally operate from a tactically superior position. In this instance, the medical profession's control of asylums, the only legitimate institutions for the treatment of insanity, effectively shut out all potential competitors; for the latter would have had to oppose unsubstantiated claims to demonstrated performance. Furthermore, the asylum doctors' institutional base gave them a powerful leverage for getting the community to utilize their services (thereby indirectly supporting their professional authority), quite apart from whether those doing so were convinced of their competence. For while employment of the asylum by the relatives of 'crazy' people or by local Poor Law authorities did not necessarily reflect acceptance of the superintendent's claims or his esoteric definition of what was 'really' wrong with the troublesome people they sent him; yet still their ready use of his services unavoidably added to the aura of legitimacy surrounding his activities. So long as his services were in such demand, it was difficult to avoid concluding that he was performing a useful and valuable task for the community (44).

If the attractions of a convenient institution in which to dump the undesirable sufficed to ensure at least the passive acquiescence of the asylum doctors' true clients, the families and parish officials, in their continued existence, it should be quite clear that their nominal clients, the asylums' inmates, had little choice but to cooperate in sustaining their definition of the situation. Freidson has argued that, for the profession of medicine as a whole, "a significant monopoly could not occur until a secure and practical technology of work was developed" (45). In essence this was because doctors could not force clients to come to them, they had to attract them. Fortunately for psychiatrists, they formed an exception to this generalization, because

(44) Freidson has argued that analogous arrangements perform similar functions in bolstering the authority of other professions. Very frequently, 'conformity is obtained because of command over accessory re-

(45) Freidson 1970a, p. 21.
of the peculiar structural characteristics of their practice. Once they had secured control over asylums, they no longer had to attract clients—the institution did that for them (46). And once patients were obtained, they formed literally a captive audience held in a context which gave immense power to their captors (47). Consequently, psychiatry was able, like the scholarly professions, to “survive solely by gaining the interest and patronage of a special, powerful sponsor without having to gain general lay confidence” (48).

Essentially, then, the asylum doctors’ position depended on whether the sponsoring elite had any reason to disturb the monopoly they had gained. Here again, being the tenant in possession so to speak, psychiatry’s position was inherently a strong one. To obtain a monopoly in the first place, others must be persuaded that positive benefits will ensue for someone other than merely the group on whom immunity from competition is conferred. But for the privilege to survive once granted, it is enough “that the dominant elite remain persuaded of the positive value, or at least the harmlessness, of the profession’s work” (49). Even failure in key areas may be tolerated, provided there are compensating benefits from allowing the perpetuation of the existing state of affairs.

Fortunately for the psychiatric profession, their inability to produce significant numbers of cures was of only slight concern to their sponsors. For there had emerged a widespread consensus among local and national elites on the value of a custodial operation (50); so that the impact of occasional grumbling about the asylum doctors’ performance was muted, and the sort of sustained criticism which might have undermined their position simply failed to materialize. Moreover, their ability (or lack of ability) to produce cures by no means exhausted the asylum doctors’ usefulness. They were, after all, no worse than anyone else as administrators, and their medical skills were useful in ministering to the numerous physical ailments of the decrepit specimens the asylums were continuously receiving. And by sustaining the illusion that asylums were medical institutions, they placed a humanitarian and scientific gloss on the community’s behavior, legitimizing the removal of difficult and troublesome people whose confinement would have been awkward to justify on other grounds.

However, if there was little reason for the authorities to revoke the monopoly they had originally granted to the asylum doctors, there

(46) For documentation of this point, see Scull 1974, ch. ix.
(48) Freidson 1970 a, p. 22.
(49) Freidson 1970 a, p. 73, my emphasis.
were also slender grounds for the grant to them of the kind of autonomy which ordinarily goes with professional status. As men with medical training, asylum doctors might have expected to be granted that freedom ‘from technical evaluation and control’ by others which such a background ordinarily confers (51). But the best medical opinion conceded that “ordinary medicines, which are the principal remedies for disease of the body, are only exceptional and accidental agents in the treatment of disease of the mind” (52). And the low cure rates characteristic of the asylum system as a whole rendered implausible the claim that psychiatrists possessed even non-pharmaceutical remedies with any real efficacy.

In this situation, “magistrates, like other mortals, have had their convictions strengthened, that medical superintendents, considered in their professional capacity, are rather ornamental than essential members of an asylum staff; very well in their way in cases of casual sickness or injury, useful to legalize the exit of the inmates from the world, and not bad scape-goats in misadventures and unpleasant investigations into the management, and in general not worse administrators [...] than would be members of most other occupations and professions” (53). The magistrates on asylum committees were in sufficiently close and frequent contact with the routine practices in these institutions that they could scarcely avoid the perception that “the medical superintendent of most English asylums is simply an overseer or onlooker, and his place might be filled by a layman of moderate intelligence, did not the law require medical qualifications, and did not accidents and emergencies arise in such establishments for which medical skill is called in requisition” (54). From quite an early period in the history of the county asylums, there were complaints from the superintendents of their employers’ “forgetfulness that insanity is a disease, and their consequent want of due appreciation of medical science in its treatment” (55).

Legally speaking, the superintendents of county and borough asylums were merely the salaried employees of individual asylum committees, each of which consisted of a group of magistrates chosen for the task at the local General Quarter Sessions. These laymen could, if they so chose, issue detailed directives as to the conduct of the institution, and could, if necessary, enforce their views by using their power to dismiss a superintendent without further appeal at

(51) Freidson 1970 a, p. 25.
(53) Arlidge 1859, p. 104.
(54) Clark 1869, p. 233.
(55) Asylum Journal No. 1, Nov. 5, 1853, p. 6.
any time. A few extraordinarily energetic committees actually exercised their enormous discretionary powers, and were heavily involved in the routine governance of ‘their’ asylums (56). Most, however, did not go to these lengths, satisfying themselves with laying down general guidelines as to the conduct of the institution. Having control over the key area of finance, they were content to leave the more mundane matters in the hands of their presumably capable subordinate, subject always to his rendering an annual account of his discharge of that trust, and to their own periodic tours of inspection.

Where the conduct of their underlings did not satisfy them, committees did not hesitate to invoke their authority to dismiss them, even over the objections of professional colleagues and of the Commissioners in Lunacy. Not surprisingly, the Association of Medical Officers of Asylums and Hospitals for the Insane proved acutely sensitive about this power of arbitrary dismissal. One case it fought particularly hard was John Millar’s ouster as head of the Buckinghamshire County Asylum in 1856.

Millar was widely regarded as a competent superintendent and possessed a high professional reputation. Even the magistrates who discharged him conceded that in previous years “Mr. Millar possessed the general confidence of successive committees” (57), and the records for this period show that his skill had frequently been commended both by his employers and by the Commissioners in Lunacy. However, following the emigration of his chief supporter, Mr. Carrington, who had served as chairman of the magistrates’ committee, he abruptly lost the support of the remaining magistrates (58), and was dismissed, ostensibly on the grounds of vague charges of maladministration (59).

Millar refused to concede defeat. He published a pamphlet in his own behalf, and obtained the intervention of the Association of which he was a member. John Hitchman, superintendent of the Derbyshire County Asylum and the Association’s president, began by sending a letter in his official capacity inquiring into the Committee’s reasons for its decision. The response was a curt note indicating that “the Committee do not recognize the authority of any such constituted Association to submit to them the questions your

(56) E.g., the Middlesex Magistrates: Cf. the Annual Reports of Hanwell and Colney Hatch Asylums, passim; and Granville 1877, vol. I, p. 150.
(57) Bucks County Asylum Annual Report 1857, p. 3.
(58) Bucks County Asylum, Superintendent’s Diary, Oct. 24, 1856.
(59) In SCULL 1974, ch. VII, pp. 453-454, I have suggested that the real reason was probably pressures from cost conscious Poor Law Officials.
letter [...] contained”. In an effort to bring further pressure to bear, the Association drew up a letter and secured the signatures of eighty-six doctors, including the major figures in contemporary English psychiatry—men like Daniel Hack Tuke, John Charles Bucknill and John Conolly (60). This was then ‘extensively circulated’ to all the leading people in the county, the signatories complaining that “this dismissal has been the occasion of alarm and profound discouragement to the medical men who have charge of fifteen thousand of the insane poor of this kingdom”, and deploring the likely effects on the quality of men attracted to the field, were this ‘ignominious dismissal’ upheld.

The Commissioners in Lunacy added their regrets “that the Institution is about to lose the services of Mr. Millar to whom the present creditable state of the patients is, in our opinion, mainly due” (61). But the Committee simply stood its ground, and lacking any sanctions with which to force a change of mind, the Association and Millar himself were forced to concede defeat. In this, as in other similar cases (62), the asylum doctors were simply unable to establish themselves as “the prime source of the criteria that qualify a man to work in an acceptable fashion” (63). Thus, in an important sense, psychiatry, at least in the public sphere, still lacked one of the crucial appurtenances of a profession. It remained an isolated specialty, with only superficial ties with the rest of the medical enterprise. And while the asylum doctors’ class origins and medical training prevented such developments being carried to an extreme, both their salaries and their prestige remained conspicuously low (64).

The superintendents’ work situation contributed to this isolation. Almost all of them were lodged either in special quarters in the main asylum buildings, or, more typically, in a house built for them in the grounds; and their manifold duties ensured that they ventured beyond the asylum walls scarcely more frequently than their patients. This

(60) All this correspondence is reproduced in the Bucks County Asylum Annual Report for 1857.
(61) Ibid. p. 34.
(62) For protests against the dismissal of the medical officer of the Norfolk County Asylum, cf. Asylum Journal, No. 7, August 15, 1854, pp. 99-102. For the discharging of Dr. Millson, the first superintendent of the Northampton County Asylum, see SCULL 1974, ch. vn, pp. 456-457.
(63) FREIDSON 1970 a, p. 10, emphasis in the original.
(64) Cf. ARLIDGE 1869, pp. 113-114; and compare the testimony of Lord Shaftesbury: “I am sorry to say that in the county asylums they are most cruelly underpaid in many instances”, House of Commons 1859, p. 60. Cf. also ibid. pp. 87-88, where he points to such cases as Hanwell, where Dr. Begley, after twenty years’ service, received no more than £200, with his house and an allowance of rations. See also the corroborating evidence of John Conolly, ibid. p. 174.

292
physical and social segregation was encouraged by (one might almost say enforced by) their employers, who adhered to the recommendation made by the Lunacy Commissioners that the asylum doctor should "be precluded from private Practice, and should devote his whole time and Energies to the Duties of his Office" (65). Indeed, his administrative burdens were so heavy as to make the asylum almost a self-contained world, wherein "the medical officer is especially prompted —if he wish to stand well with the Committee—to develop the moral management and domestic economy to the utmost; to exhibit well-kept wards, well-clothed and well-fed patients, well-filled workrooms, and a well-stocked and worked farm; and, above all, a good balance from the patients' earnings, as a set-off to the cost of their maintenance" (66).

The relevant reference group for the psychiatrists' status concerns remained the medical profession as a whole, though judging by their responses, the latter seem to have found the mad-doctors a somewhat embarrassing excrescence. Almost twenty years after the establishment of their professional association, and despite numerous efforts to rectify the situation, psychiatrists had to concede that "the study of mental disorders is studiously excluded from the medical curriculum, alienist physicians, as they are therefore well called, work in a department of science the first principles of which are not recognized by their medical brethren, and seem often to speak a language not understood by those around them [...] so few of even our most accomplished professors [of medicine] have any knowledge of the various types of mental derangement [...]" (67). And according to Hunter and MacAlpine, the "segregation of psychiatry from medicine if anything became more pronounced as time went on" (68).

By and large, asylum superintendents seem to have accepted this somewhat ambiguous professional status, and to have worked uncomplainingly within the limits of the authority granted them by their employers (69). It was otherwise with some of the leading figures

(68) Ibid. The most eminent physicians in the field seem to have had the greatest difficulty adjusting to the low status of their chosen specialty. Bucknill, for instance, sought to explain it as follows: 'Do we not sacrifice the good-will of the community, not so much for the shortcomings, which in our great task are inevitable, but because the public extends its unreasonable antipathy to the insane, to all who are connected with insanity'. Bucknill 1860, cited in ibid, p. 1064.
(69) See, for example, the annual reports of the Hanwell, Colney Hatch, Northamptonshire, and Littlemore County Asylums, and those of the Buckinghamshire County Asylum from 1858 on, under Millar's successor, Humphry.
in the field, those who, by their eminence had attained positions outside the County Asylum system (70), or who had managed to pursue careers outside that system entirely (71). These men were clearly not satisfied with psychiatry's marginal status in medicine, and realized that their professional autonomy was compromised by the obvious lack of application of the medical model in the huge custodial institutions of the period. It was from their ranks that the most vigorous critics of the asylums' complacent custodialism were recruited (72). And it was they who sought, almost desperately, to assert that all aspects of the treatment of insanity were a medical province, and that asylum doctors should therefore be immune from interference by unqualified laymen. The profession was warned that "the notion that medicine is inoperative in mental disorder has produced much mischief" (73) and was urged to guard against "the exclusion or [...] the undue disparagement of physical means of cure and alleviation" (74) lest there be a return to the "past when the skill and experience of the physician was thought to be less important than the watchful care of the matron or steward" (75). It was the asylum superintendent's task to emphasize that "the just medium has been passed, and the insane are suffering by the present extreme views" which depreciated the value of medicine (76). To the contrary, the importance of conventional medical treatment must be repeatedly stressed (77).

The difficulty here lay in the fact that it did little good to advocate a greater emphasis on medical techniques as a means of raising psychiatry's prestige, or to attribute the low status of asylum doctors to "the laudation by physicians of the so-called moral means of treatment, and the oblivion into which medical aid has been allowed to fall" (78) when the medical remedies which could prove their worth in practice simply did not exist. An alternative tack therefore became popular (70) E.g., John Charles Bucknill and Lockhart Robertson, formerly superintendents of the Devon and Sussex County Asylums respectively. (71) E.g., Arlidge, Clark, Maudsley, Granville. (72) Cf. SCULL 1974, ch. vii, pp. 427-428; SCULL 1976, chs. vi and vii. (73) ARLIDGE 1856, cited in HUNTER and MACALPINE 1963, p. 1027. (74) BROWNE 1864, p. 5. (75) HOOD 1862, p. 104—an obvious reference to the York Retreat. (76) ARLIDGE 1856, cited in HUNTER and MACALPINE 1963, p. 1027. (77) Since there were plainly no effective medical therapies for the treatment of insanity, it is not at all clear how the authorities' scepticism about the value of medical treatment could have been harming the insane, though it is obvious why their doctors should find it detrimental. As Arlidge pointed out: 'It has induced magistrates to hold medical men in little estimation as physicians of asylums, and to view them merely as useful and superior stewards in directing the general management and moral treatment, and as safeguards of casualties and of accidental disease'. ARLIDGE 1856, cited in HUNTER and MACALPINE 1963, emphasis in the original. (78) ARLIDGE 1869, p. 104.
with those intent on raising the profession’s prestige and resisting outside, “lay” interference. If the proportion of patients cured failed to rise in the years following the rapid expansion of the asylum system, so that claims that the medical (i.e., pharmaceutical) treatment of insanity had greatly improved were likely to be received with scepticism, there remained one aspect of the condition of lunatics where no one doubted that there had been progress. As Daniel Hack Tuke put it, “so far as this includes moral treatment and management, it has advanced in all civilized countries in a manner calculated, all will admit, to cause the liveliest feelings of satisfaction” (79). In consequence, those who were convinced that “there is no more dangerous delusion in the range of lunacy than this notion that the care and treatment of the insane is not wholly medical” (80), now sought to claim that moral treatment itself (or as some preferred to call it “medico-moral treatment”) (81) was something only physicians were qualified to dispense.

Beginning with the simple assumption that “the moral system of treatment can only be properly carried out under the constant superintendence and by the continuous assistance of a physician” (82), the profession eventually developed a more elaborate set of arguments for the position that moral treatment by itself provided sufficient justification for ensuring that it is “the medical authority that controls everything in an asylum for mental disease”, entirely free of all outside interference (83). As Granville put it: “It would be just as reasonable, or unreasonable, for the lay officials of an ordinary hospital to prescribe the drugs or instruments with which physicians and surgeons treat physical disease, as for lay authority to be combined with the medical in an asylum for the insane [...] for the simple and obvious reasons, that disease of the mind is amenable only to the influence of moral remedies, and the discipline, the control, the daily routine and management of the insane are the ‘drugs’ with which the physician of the mind must work the cure of his cases” (84). As this implies, all

(79) Tuke 1882, p. 484.
(80) Granville 1877, vol. II, p. 149. One is tempted to ask here, dangerous to whom? Surely not to the lunatics themselves, for had the asylum doctors been able to demonstrate the efficacy of medical treatment in curing insanity, it is, to say the least, unlikely that the authorities would have stood in the way of its application, since the latter’s primary concern was with reducing the financial burden of maintaining the insane to a minimum. But such a pernicious doctrine clearly endangered the professional autonomy of the asylum doctors themselves.
(81) E.g., William Ley in Littlemore County Asylum Annual Report 1855, p. 9.
(84) Ibid. pp. 77, 150.
aspects of asylum administration were now alleged to form part of the system of moral treatment; a system whose components were so closely linked one to another that unschooled intervention at any point threatened the whole edifice.

From the very outset, the design of the physical structure of any asylum required continuous consultation with, and deference to, the accumulated expertise of this branch of the medical profession. After all, “an asylum is a special apparatus for the cure of lunacy, and ought to be constructed under the direction of the physician by whom it is to be employed, or by an expert in the uses to which it will be subsequently applied” (85). And once the asylum was in operation, magistrates’ committees must somehow be taught to resist the temptation to meddle in questions which were beyond their competence to decide. As to where that boundary might lie, if the more uninhibited protagonists of medical control were to be believed, almost everything was beyond any layman’s competence. Granville, for instance, reported that the Middlesex magistrates had ordered their superintendents to make changes in the asylum’s diet, so as to lessen its monotony. But while their actions were clearly well-intentioned, and the consequences in this particular instance were harmless (or even beneficial), “it is impossible to admit that a lay committee has any ground or qualification for the task of forming a judgement on a point of this nature” (86). Apparently only a physician was qualified to recognize and ‘treat’ monotony. The trouble was, that “this, unfortunately, is what visiting committees do not perceive” (87) and persisted in not perceiving. Questions of diet, decoration, and amusement were ones in which many laymen continued to feel they were as qualified as any professional (as, of course, the originators of moral treatment had contended they were); and consequently, for all the well-wrought arguments of men like Granville, asylum committees continued to interfere in the administration of their asylums whenever it suited them to do so (88).

So far, I have been largely concerned with the external aspects of the psychiatric profession’s efforts to consolidate its position—that

(85) Ibid. p. 15.
(86) Ibid. p. 127.
(87) Ibid. p. 15.
(88) Cf. Freidson’s discussion of Florence Nightingale’s efforts to ‘professionalize’ nursing. (FREIDSON 1970 a, pp. 60-63). Similar tactics were employed in this effort: “Even such unskilled tasks as feeding a patient were [...] defined as part of the medical regimen [...] thus nursing became [...] a technical task rather than a ‘natural’ practice of femininity or a part of the exercise of charitable impulses” (ibid. p. 61). Here however, these routine tasks served as a basis for far less exalted claims to professional status than those the asylum doctors were compelled to make.
is, with the threats to the asylum doctors' status and dominance originating outside the institution. Although decisions in these areas clearly had implications, often serious ones, for the superintendents' conduct of the asylums themselves, there also existed a set of problems which bore more directly on the issue of the physician's authority within the institution. I want, therefore, to conclude this paper by indicating what these difficulties were, and how the asylum doctors attempted to resolve them.

Arlidge complained that asylums had grown so large that "asylum superintendents [...] are driven to a system of routine and general discipline, as the only one whereby the huge machine in their charge can work, and look upon recoveries as casual coincidences or unde signed coincidences" (89). What he overlooked was the potent protective functions such a situation provided for the psychiatric profession. For one of the crucial problems for any occupation whose results blatantly fail to measure up to its claims is to insulate its members from the consequences of this failure—partly, of course, those which may flow from the discontent of its clients; but also, and perhaps of equal importance, the loss of morale and belief in themselves among its own members.

The asylum doctors' inability to do anything for the overwhelming majority of their patients meant that interaction with inmates threatened daily disconfirmation of their effectiveness. In this situation, being asked to undertake impossibly heavy caseloads in a patently over-large institutions provided the profession with a convenient scapegoat on which to blame many of its troubles. As one would expect in the circumstances, there were complaints that because the physician had "his mile or so of wards and offices to perambulate daily", and four or five hundred inmates to consider, he could not possibly be expected to employ the full resources of his healing art; and stories were told before official inquiries to illustrate just how unreasonable it was, in consequence, to expect cures, given the trying conditions doctors were forced to work under (90); but there was no sustained

(89) ARIDGE 1859, p. 103.

(90) 'I recently asked the superintendent of a large asylum how long it would take him to go round his wards if he bestowed a short time on each case. He said: "If I gave one minute to each of my patients it would take me eleven hours"'. House of Commons 1877, evidence of J. Mortimer Granville. Some asylum committees actually required their medical officers to see each patient each day. How this apparently Herculean task was accomplished was suggested by evidence given before an earlier Select Committee: Q. — 'According to your regulations, you expect them to see every patient? A. — Yes; once at least every day. Q. — Take the case of the 600 female patients, if each of them were seen for only a minute [by the one doctor], it would take ten hours a day? A. — But there are many who might be seen in much less than half a minute; you walk through the wards, you
ANDREW T. SCULL

effort on the part of the asylum doctors to reduce their task to manageable proportions, or to secure adequate staffing of asylums.

To the contrary, they resisted suggestions which would have relieved them of the burden of caring for chronic patients (91); and, as I shall show in a moment, instead of welcoming efforts by outsiders to rid them of their administrative functions, so as to allow them to devote their full energies to the cure of patients, they fiercely resisted all such proposals, and insisted on burying themselves ever deeper in administrative concerns. Asylums were so large, and so crowded with physically decrepit specimens, that the superintendent's assistant physicians, who were forced to have some daily contact with the patients, could safely spend all that time in providing routine medical care for ordinary physical ailments; thereby, of course, affording confirmation that they were engaged in supplying a medical service to the inmates (92).

Even the assistants, however, found ways to minimize the amount of time they were forced to spend in the unpleasant and disturbing company of (live) patients. Particularly popular, if the figures given in the annual reports of the Commissioners in Lunacy are to be believed, was research on dead bodies, which even though it might be repetitive and lead nowhere, at least bore a passing resemblance to more conventional medical practices (93)! In the meantime, the dirty work of dealing with the patients on a day-to-day, hour-by-hour basis was left to a staff of attendants, themselves recruited from the dregs of society; men and women who, in return for long hours spent in close, defiling contact with the insane, received suitably low status and financial rewards (94). Thus insulated from the reality of asylum existence, the superintendent was able to remain a remote, if benevolent despot; his position above the crowd and freed from too close

know them all [sic!], and it is not a medical examination which takes place of every patient on every side'. House of Commons 1859, p. 238, evidence concerning Hanwell County Asylum.

(93) The practice grew in popularity in the course of the century. In 1870, for example, 1,336 autopsies were conducted (42% of all asylum deaths in the year); By 1890, the number had risen to 4,336, (76.6% of all asylum deaths). Commissioners in Lunacy, vol. XXV, 1871, p. 39, and vol. XXXXV, 1891, p. 40.

(94) Conolly described them as follows: 'Attendants are generally persons of small education, and easily inflated by authority; they love to command rather than to persuade, and are prone to consider their patients as poor lost creatures, whom they may drive about like sheep'. (Cited in Edinburgh Review 1870, p. 222.) On their remuneration, compare W. G. Campbell, a Lunacy Commissioner: 'I find on reference to a return from prisons, that the gaolers of prisons receive more than double what the attendants in asylums receive'. House of Commons 1859, p. 58. See also House of Commons 1877, p. 39.
and frequent contact with the patients protected him from the contamination, not just of his social position, but, indirectly, of his authority as well (95).

Perhaps a more serious threat to the asylum doctor’s authority than his potential loss of confidence in his own skills, or of the deference shown him by his patients, was one which is generic to all types of professional authority, but which was here experienced in a peculiarly acute form. As Freidson has pointed out, “the authority of expertise is in fact problematic, requiring in its pure functional form the time-consuming and not always successful effort of persuading others that its ‘orders’ are appropriate” (96), rather than relying, as does bureaucratic authority, on the application of rewards and penalties to obtain compliance. Obviously, the task of persuasion is made easier to the extent that a given group of experts can provide plausible evidence that its approach brings substantially superior results to those which would have ensued in the absence of the application of their special skills; and/or the more nearly the experts and those whom their service is intended share a common universe of discourse. Both of these factors, however, served only to exacerbate the problems psychiatry faced in maintaining its professional authority. In the first place, the asylum doctors’ basic claim to possess expertise in the treatment of insanity was a fragile one, and not one in support of which they could readily produce convincing evidence in the form of large numbers of cures. Secondly, it is probable that there existed here an even more profound disjunction than usual between professional and lay world views. Neither the uneducated classes recruited as attendants in asylums, nor the social derelicts who formed the bulk of the asylums’ population, were likely to share in any significant degree the profession’s perspective on insanity. That perspective, after all, was a relatively novel one; and it was one to which the asylum doctors had been concerned to convert the elite, not the masses.

Even in those instances where the special skill possessed is demonstrably powerful and effective, “professions have attempted to solve the problem of persuasion by obtaining institutional powers and

(95) The pernicious effect of too familiar and intimate association with one’s inferiors on the deference accorded those of higher status (which was so deeply rooted a feature of Victorian society), was duly noted by Granville who warned: ‘The circumstance of a superintendent’s wife acting as matron involves a sacrifice of social position injurious, if not fatal, to success. It is above all things indispensable that medical superintendents of asylums should be educated gentlemen; and if that is to be the case, their wives cannot be matrons. Indeed, it is inconceivable that a man of position and culture would allow his family to have any connection with an asylum.’ Graville 1877, vol. 1, p. 99, my emphasis. So much for his emphasis that the insane were ‘sick people’.

(96) Freidson 1970 b, p. 131.
prerogatives that at the very least set limits on the freedom of their prospective clients and that on occasion even coerce their clients into compliance. The expertise of the professional is institutionalized into something similar to bureaucratic office” (97). Consequently, where claims to the authority of expertise are themselves weak and tenuous, one can certainly expect that the quest to supplement this with the authority of office will acquire extraordinary urgency and importance.

In the context of the asylum, securing the authority of office meant restricting the position of asylum superintendent to medical men, and investing that position with power over all aspects of asylum administration, including personnel questions as well as matters more strictly related to the treatment of patients (98). In the earliest asylums, the medical profession accumulated such powers almost fortuitously. The asylums were small, and the local magistrates were but little inclined to pay two salaries where one would do. Accordingly, once the justices had been convinced that lunatics required almost constant medical assistance, the doctor employed for this purpose was generally expected in addition to take charge of the day-to-day administration of the asylum (99).

However, the rapid expansion of the number of lunatics and the associated rise in the average size of public asylums posed something of a threat to this cosy arrangement. For in asylums containing several hundred inmates, “when to the medical and moral treatment of the patients are added the multifarious duties comprised under the terms ‘general management and superintendence’, [...] it will be readily conceded that [...] those labours are far too onerous to be adequately performed by a single individual” (100). A logical solution to the problem, which could be expected to occur to some asylum committees at least, was to hire a full-time lay administrator to assume the routine duties of running the institution, thus allowing the asylum doctor to devote his full time and energy to the task for which his professional training had presumably prepared him, the cure of patients.

(97) Ibid.
(98) In practice, this was a distinction which the asylum doctors refused to acknowledge existed. Everything was relevant to cure, and hence nothing could be safely delegated to lay hands.
(99) It is significant that where magistrates were initially inclined to doubt the value of medical intervention, as at Bedford, so that medical attendance on asylum inmates was slight or non-existent, local medical men made vigorous and ultimately successful efforts to ensure not merely regular professional treatment of the patients’ pathologies, but also the appointment of a resident physician to whom the existing lay administrators were to be subordinate in all respects. Cf. Scull 1975, pp. 247–250.
(100) Commissioners in Lunacy Report on Bethlem Hospital, 1852, p. 15.
The superintendents, though, evinced no desire whatsoever to adopt this policy or to rid themselves of their mounting burden of administrative duties. To the contrary, they insisted on assuming them. Where, as at Hanwell, asylum committees attempted to institute such a separation of powers, the physicians in residence, backed by the profession as a whole, did their best to render such schemes unworkable (101). More generally, recognizing that the question of lay versus medical administrators “is one in which the profession as a body has a direct concern, and in which every practitioner of ‘psychological medicine’ must feel his status immediately involved” (102), psychiatry’s publicists sought by all means at their disposal to convince the public that “the interests of science and the obligations of true economy alike require that public asylums should be ‘hospitals’ under medical management [...]” (103). These efforts were crowned with success. Asylum committees everywhere, even those which had flirted with the idea of lay administrators, conceded what the doctors wanted. Rather than dividing his authority with a lay administrator, the medical superintendent was to be given the assistance of one or more assistant physicians to perform the necessary medical chores, while he concentrated almost his entire energies on administration. Henceforth, the further an asylum doctor’s career progressed, and the more experience he gained, the less his contact with the insane. But at least psychiatry had buttressed its weak claims to the authority of expertise with the authority of a near-autocratic office.

To sum up briefly, how successful were nineteenth-century psychiatrists in establishing the treatment of insanity as a professional domain? Certainly they managed in large degree to maintain their quasi-monopolistic position in the field. But, though possessed of a legally enforceable monopoly, the psychiatrists were without a secure base of expertise; a problem difficult to disguise from outsiders because it had a clear practical consequence—an inability to ‘cure’ more than a small minority of those receiving professional ‘treatment’. The legal guarantees of psychiatry’s position modified the deleterious consequences that might have been expected to flow from this weakness; but they could not eliminate them entirely. It is true that mad-doctors were able to resist quite well the various assaults on their professional identity which had their origins within the asylum itself; and to cement the weak authority they derived from their expertise to a much more powerful authority deriving from their insti-

tutional position. Moreover, within their protected enclave, the asylum, psychiatrists had the opportunity to develop craft skills in dealing with the insane, an opportunity denied to all their potential rivals. No one made any serious effort to break into the field, for none was likely to succeed or seem plausible—the lack of practical, demonstrated capacity on the part of any challenger was simply built into the system. At the same time, the underlying weakness of the profession’s claim to possess a superior cognitive basis for the treatment of insanity left it virtually unable to resist ‘lay’ pressure from uncertified groups of men involved in asylum management.

In almost all aspects of their work, psychiatrists were subject to outside (lay) interference, evaluation, supervision and even control. They remained, that is, conspicuously mired in the status of salaried employees. And this lack of autonomy, of control over the conditions and conduct of their work, was such that one is tempted to call into question their professional status. Perhaps it is only because they remained so firmly attached to medicine’s coat-tails that one hesitates to do so.

I would suggest, however, that for all the undoubted weaknesses of psychiatry’s professional position at the close of the nineteenth century, its retention of an institutional base in the asylum was of extreme importance in accounting for its later acquisition of the other accoutrements of a profession. With its cognitive monopoly assured, and already possessed of a captive market, it needed only to develop a plausible esoteric theory and a course of professional training in order to do so. Here I suspect that a key role was played by Freudian ideas, despite the obvious impracticality of applying them in an asylum context. For the Freudian system possessed a combination of almost unsurpassable virtues as a professional ideology. It had the great merit of being not testable, and hence not refutable; and, like Marxism, it lent itself to simplification for the simple and sophistication for the sophisticated. Requiring prolonged and costly training, it developed a presumptive expertise in its devotees which readily justified a rejection of outside, non-professional interference; a dogma which even provided an ‘explanation’ of why such ‘irrational’ resistance to its method should arise in the first place—thus discrediting its critics while protecting itself from the dangerous task of actually having to supply substantive answers to the objections they might raise. Moreover by encouraging the development of the whole new realm of office practice, coping with upper-class neurotics, psychiatry was at once able to dilute the ill effects of overly-close association with the poor, the stigmatized, and the unwanted; and to establish among
the elite its credentials as a doubly worthy enterprise. Thereafter, having secured psychiatry's position vis-à-vis the insane, it has provided the basis for the profession's subsequent efforts to engulf other forms of deviance, and to reduce these, too, to a medical paradigm.

On their own terms, with respect to their ability to 'cure' their subjects, the experts in the control of deviance in modern societies have been spectacularly unsuccessful—which raises the question of why they are still accorded the status of experts. Looking at the case of psychiatry, with which I have here been concerned, it is clear that in practice psychiatrists in the nineteenth century did little more than act as caretakers of custodial dumping institutions. Nor did it require much sophistication or inquiry to uncover the fact. It was too blatantly obvious to be overlooked—or so it might seem. Yet, despite this, the medical superintendents of asylums continued to claim and to be formally recognized as experts in the treatment and cure of 'mental illness'. Only a few cranks, and some asylum inmates (104), seem to have voiced the opinion that the emperor had no clothes.

I suggest that such a persistent, almost willful blindness derives from something more than the sacred and hence unquestioned quality with which modern societies have endowed science and certified expertise. It is true, of course, that such unexamined deference is habitually exhibited in its most acute form in the realm of medicine. Indeed, the doctor-patient relationship is so structured as to demand routinely that the client abdicate his own reasoning capacity (105). In its place is fostered a naive child-like faith that the physician is operating in the patient's best interests; and that, while he does so, he is guided by an esoteric training and knowledge giving him insights which are beyond the powers of ordinary mortals to grasp or understand. But, when all is said and done, modern medicine, much of the time at least, has results, if not God, on its side. English psychiatry at the end of the nineteenth century (and most of the 'experts' currently engaged in the control of deviance) clearly did (do) not.

And yet, if asylums, and the activities of those running them, did not transform their inmates into upright citizens, they did at least get rid of troublesome people for the rest of us. By not inquiring too deeply into what went on behind asylum walls, and by not being too sceptical of the officially constructed reality, people were (are)

(104) A constant complaint made by inmates of English lunatic asylums to the Lunacy Commissioners, throughout the nineteenth century, was that they did not belong in asylums and that nothing was being done to cure them anyway.

(105) Freidson 1970 b, pp. 119-121.
rewarded with a comforting reassurance about the essentially benign character of their society and the way it dealt (deals) with its deviants and misfits. Granting a few individuals the status and perquisites ordinarily thought to be reserved for those with genuine expertise and esoteric knowledge was a small price to pay for the satisfaction of knowing that crazy people were getting the best treatment science could provide, and for the comfortable feelings which could be aroused by contemplating the contrast between the present ‘humane’ and ‘civilized’ approach to the ‘mentally ill’ with the barbarism of the past (106).

(106) For a more general discussion of these issues, cf. Hughes 1964.
MAD-DOCTORS AND MAGISTRATES


Steward, J. B., Practical Notes on Insanity (London, Churchill, 1845).

