

Professional Identity and the Nineteenth-Century Ontario Medical Profession

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This article discusses the formation of the Ontario medical profession and what it meant to be a professional physician in Ontario in the nineteenth century. Using textual sources and an empirical analysis of the numbers and educational patterns of physicians and how these changed from 1820 to 1869, the author argues that the Ontario medical profession was created well in advance of the legislation that created the College of Physicians and Surgeons of Ontario in 1869. The professional identity of Ontario physicians was rooted in appeals to gentility and credentials, which made it distinct from the American and akin to the British medical professions.

Cet article porte sur l'apparition de la profession médicale en Ontario et sur la vie de médecin au XIX^e siècle. L'auteur s'appuie sur des documents et sur une analyse empirique de l'évolution du nombre et de la scolarité des médecins de 1820 à 1869 pour affirmer que la profession médicale a vu le jour en Ontario bien avant l'adoption, en 1869, de la loi créant l'Ordre des médecins et chirurgiens de l'Ontario. Les médecins ontariens fondaient leur identité professionnelle sur l'appel à la bonté et à l'acquisition des compétences, ce qui les différençait des médecins américains et les apparentait aux médecins britanniques.

THE RISE OF PROFESSIONS in the nineteenth century has been a much-studied phenomenon.¹ Doctors have been successful in garnering an occupational monopoly and the authority to regulate themselves, as well as prestige and financial rewards, making the creation of the modern medical profession

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1 For examples of the history of the professions and professionalization generally, see Jeffrey L. Berlant, *Profession and Monopoly* (Berkeley: University of California Press, 1975); B. J. Bledstein, *The Culture of Professionalism* (New York: Norton, 1976); H. Perkin, *The Rise of Professional Society: England since 1880* (London: Routledge, 1989); Constance Backhouse, *Petticoats and Prejudice: Women and Law in Nineteenth-Century Canada* (Canada: The Women's Press, 1991).

of particular interest.² An empirical study of the numbers and educational patterns of physicians and how these changed from 1820 to 1869 sheds light on not only the formation of the Ontario medical profession but also what it meant to be a professional physician in Ontario in the nineteenth century. The statistical analysis illuminates the patterns that underlie both the rhetoric and the reform initiatives of the profession.

The process by which a profession is created or the point at which it exists is difficult to delineate exactly. Usually a modern profession is associated with such features as formal professional bodies, occupational monopoly (either legislative or *de facto*), and journals. S. E. D. Shortt has suggested that medical professionalization can be fruitfully discussed as "a process by which a heterogeneous collection of individuals is gradually recognized by both themselves and other members of society as constituting a relatively homogeneous and distinct occupational group".³ Using Shortt's definition, I would argue that the Ontario medical profession was created well in advance of the 1869 legislation that created the College of Physicians and Surgeons of Ontario.⁴ As well, the professional identity of Ontario physicians was distinct from the American, and akin to the British.

The historian J. T. H. Connor, in his study of alternative and sectarian

2 For references to the history of the medical profession, with an emphasis on the Canadian context, see M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley: University of California Press, 1978); Charles M. Godfrey, *Medicine for Ontario: A History* (Belleville: Mika Publishing Co., 1979); S. E. D. Shortt, ed., *Medicine in Canadian Society: Historical Perspectives* (Montreal: McGill-Queen's University Press, 1981); P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); Gerald V. Larkin, *Occupational Monopoly and Modern Medicine* (New York: Tavistock Publications, 1983); S. E. D. Shortt, "Physicians, Science and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century", *Medical History*, vol. 27 (1983), pp. 51-68; Ronald Hamowy, *Canadian Medicine: A Study in Restricted Entry* (Canada: The Fraser Institute, 1984); C. G. Roland, ed., *Health, Disease and Medicine: Essays in Canadian History* (Toronto: Clarke Irwin, 1984); Jacques Bernier, *La médecine au Québec : naissance et évolution d'une profession* (Quebec: Les Presses de l'Université Laval, 1986); W. F. Bynum and Roy Porter, eds., *Medical Fringe and Medical Orthodoxy, 1750-1850* (London: Croom Helm, 1987); W. Mitchinson and J. D. McGinnis, eds., *Essays in the History of Canadian Medicine* (Toronto: McClelland & Stewart, 1988); J. T. H. Connor, "Minority Medicine in Ontario, 1795 to 1903: A Study in Medical Pluralism and its Decline" (Ph.D. dissertation, University of Waterloo, 1989); R. J. Clark, "Professional Aspirations and the Limits of Occupational Autonomy: The Case of Pharmacy in Nineteenth-Century Ontario", *Canadian Bulletin of Medical History*, vol. 8 (1991), pp. 43-63; J. T. H. Connor, "'A Sort of *Felo-de-se*': Eclecticism, Related Medical Sects, and their Decline in Victorian Ontario", *Bulletin of the History of Medicine*, vol. 65 (1991), pp. 503-527; Jennifer J. Connor, "To Advocate, to Diffuse, and to Elevate: The Culture and Context of Medical Publishing in Canada, 1630 to 1920" (Ph.D. dissertation, University of Western Ontario, 1992); Michael McCulloch, "'Dr. Tumblety, the Indian Herb Doctor': Politics, Professionalism, and Abortion in Mid-Nineteenth Century Montreal", *Canadian Bulletin of Medical History*, vol. 10 (1993), pp. 49-66.

3 Shortt, "Physicians, Science and Status", p. 52.

4 After the Act of Union in 1841, the province of Upper Canada was named Canada West, and after Confederation in 1867, Ontario. For the sake of consistency, I will refer to this region as Ontario. Similarly I will refer only to Quebec (Lower Canada, Canada East).

medicine, has emphasized that in the nineteenth century Ontario was medically pluralistic, and entry into the medical profession was not wholly restricted.⁵ My emphasis, however, is different. No doubt because my research centred on the regular medical profession, which made up the vast majority of practitioners, pluralism did not emerge as the defining characteristic of the Ontario scene.

In the traditional discourse, medical professionalization tended to be characterized either as a positive process, in which the patient was guaranteed safe and effective treatment in exchange for accepting the physician's control, or as a negative process in which doctors achieved domination over competitors in the medical market at the expense of their patients.⁶ Unsurprisingly, the formation of the Ontario medical profession defies such simple explanations. The monopoly granted to the medical profession represented a compromise between public will and professional desire, and the profession in Ontario was formed in advance of modern medicine. Events in Ontario do support the contentions of the historian Matthew Ramsey that, where *laissez-faire* liberalism flourished, monopoly was weak or abolished; where mainstream liberalism was committed to centrist reforms, monopoly was weakly challenged; and, where liberalism failed, professional monopolies were tightest.⁷ Ontario had a tight monopoly and a failed liberal rebellion.

In Ontario during this period there was also a much simpler relationship between politics and medicine. Prominent politicians were also physicians. Most notably, the Reform faction, led by John Rolph, W. W. Baldwin (both physicians), and later William Lyon Mackenzie, agitated throughout the 1830s for responsible government and against the oligarchy that ruled the province. Initially their tactics were political, but eventually violent tactics were used in the Rebellion of 1837.⁸ The Rebellion was unsuccessful, since the majority of the population remained loyal to the Crown despite being sympathetic to the Reform platform.⁹ Rolph fled to the United States where he remained

5 J. T. H. Connor, "Minority Medicine", p. 400, and see also pp. 193, 198, 472.

6 For a discussion of this issue, see Berlant, *Profession and Monopoly*, pp. 11–51.

7 Matthew Ramsey, "The Politics of Professional Monopoly in Nineteenth-Century Medicine: The French Model and its Rivals", in Gerald L. Geison, ed., *Professions and the French State, 1700–1900* (Philadelphia: University of Pennsylvania Press, 1984), pp. 225–305, 229.

8 This is a simplification of events that remain contentious. According to one version, eventually Mackenzie's group broke from the more moderate Baldwin camp, which eschewed violence or any active disloyalty to the Crown; Rolph was ostensibly in Baldwin's camp but in fact aided Mackenzie. See James Henry Richardson, "Reminiscences of the Medical Profession in Toronto", Toronto Public Library, Baldwin Room, John Ross Robertson Collection, reproduced in part in S. F. McRae, "The 'Scientific Spirit' in Medicine at the University of Toronto, 1880–1910" (Ph.D. dissertation, University of Toronto, 1987); National Archives of Canada (hereafter NAC), Provincial Secretary's Correspondence, RG5 C1, v. 9, p. 1930–1931, R. E. Burns's letter of December 10, 1837, "Relative to Dr. Rolph's escape"; and the discussion in Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life* (Toronto: University of Toronto Press, 1993), pp. 13–15 and 16–17.

9 Gerald M. Craig, *Upper Canada, The Formative Years, 1784–1841* (Toronto: McClelland & Stewart, 1963), p. 249.

until the mid-1840s. The act creating responsible government for the united Canadas¹⁰ gave a legitimate outlet to the Reformers, however, and through the 1840s they gradually returned to Ontario and became an important political force in the legislature.

Statistical Analysis of Doctors in Ontario, 1820–1870

The study delineates changes in the numbers of practitioners and in their patterns of education between 1820 and 1870.¹¹ This period was chosen because the first medical board was formed just prior to the 1820s, and the founding of the College of Physicians and Surgeons in 1869 represented completion of the reforms first envisioned in the act of 1818. Although I compiled statistics both for those entering the profession and the entire profession in each decade, new practitioners illustrate more sharply the trends that emerged.¹² All of the doctors collated were men, but there is evidence that a few women may have been practising medicine by the late 1860s.¹³ I divided the physicians into five groups, one for each decade, on the basis of when, according to the available information, they first had begun to practise. Since many physicians were licensed or graduated from medical school after starting practice, assignment to a particular group was approximate in some cases.

Figure 1 shows that both the total profession, the upper curve, and the number entering the profession, the lower curve, rose in absolute numbers throughout this period. The only deviation from this trend was the decrease in the number of new practitioners in the 1840s. The number of practitioners and new practitioners increased most sharply during the 1860s.¹⁴

10 *Ibid.*, pp. 262–263.

11 Sources for these analyses were the *British American Journal*, an unofficial medical register from 1835, the *Ontario Medical Register of 1869*, the licensing documents and correspondence in the National Archives of Canada, the relevant *British Medical Directories and Registers*, and William Canniff, *The Medical Profession in Upper Canada, 1783–1850* (Toronto: 1894; Hannah Institute for the History of Medicine, 1980). I took care to collate the names gleaned from each source so that no physician was counted more than once.

12 In order to estimate the total number of medical practitioners at the end of a given decade, I needed to determine when each practitioner had stopped working in Ontario. This was not necessary for the large number of doctors who started practice in the 1850s and 1860s and were listed in the *Ontario Medical Register of 1869*. The date of departure from Ontario or death was known for many early practitioners; using these doctors' average duration of practice in the province (32 years), I estimated when other doctors ceased to practise.

13 In fact I have found evidence of only one woman practising from 1867 onwards. See Constance B. Backhouse, 'The Celebrated Abortion Trial of Dr. Emily Stowe, Toronto, 1879', *Canadian Bulletin of Medical History*, vol. 8 (1991), pp. 159–187, in which the practitioners Jenny Kidd Trout and Emily Stowe are discussed (pp. 162–163); Backhouse, in *Petticoats and Prejudice*, outlines the training of Emily Howard Stowe and the opening of her office in 1867 (pp. 139–144) and mentions Jenny Kidd Trout's training which began in 1870 (p. 144). Women were initially refused licences even if they had fulfilled the legal requirements.

14 The numbers available from the three censuses of the period that provide employment statistics are comparable to those in Figure 1. The total number of physicians and surgeons practising in 1871, according to the census, was 1,558; according to Figure 1, the number was 1,489 in 1869. In 1861

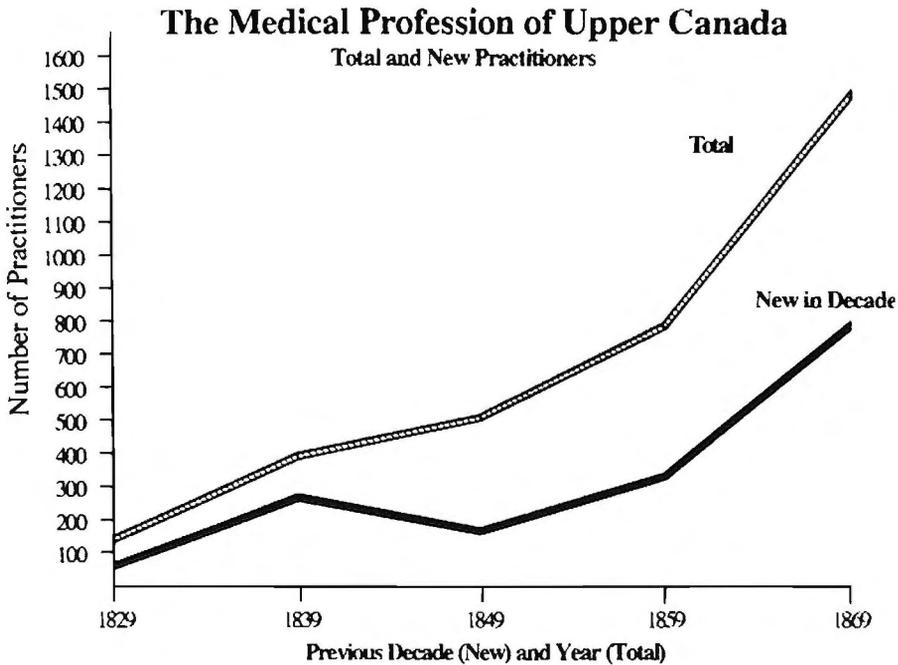


Figure 1 For sources, see notes 11 and 12.

Figure 2 illustrates the relationship between the growing population of Ontario and the growing numbers of medical practitioners.¹⁵ The solid line shows how many new practitioners there were for every new inhabitant of the province in a given decade. The other shows the number of practitioners for every inhabitant of the province. It is noteworthy that the number of practitioners relative to the size of the population remained fairly constant over the period.

the census counted 883 doctors; I found 787 doctors in 1859. The largest deviation from my results comes with the census of 1851, which counted 382 practitioners compared to the 511 I found in 1849. Since I have estimated when doctors ceased to practise it is possible that I have overestimated the number of practitioners; Gidney and Millar, however, have estimated that there were between 400 and 500 practising physicians in Upper Canada in 1850. They also noted that the census count of physicians and surgeons of 1861 had omitted several regions of the province. R. D. Gidney and W. P. J. Millar, "The Origins of Organized Medicine in Ontario, 1850-1869", in Roland, ed., *Health, Disease and Medicine Essays in Canadian History*, p. 65 and n. 54, p. 93.

¹⁵ The population figures were obtained from the Public Record Office (PRO), London, England, Blue Books of Statistics, CO 47, nos. 141-170 (Upper Canada) 1821-1841, (Canada) 1842-1855, and the censuses for 1851, 1861, and 1871.

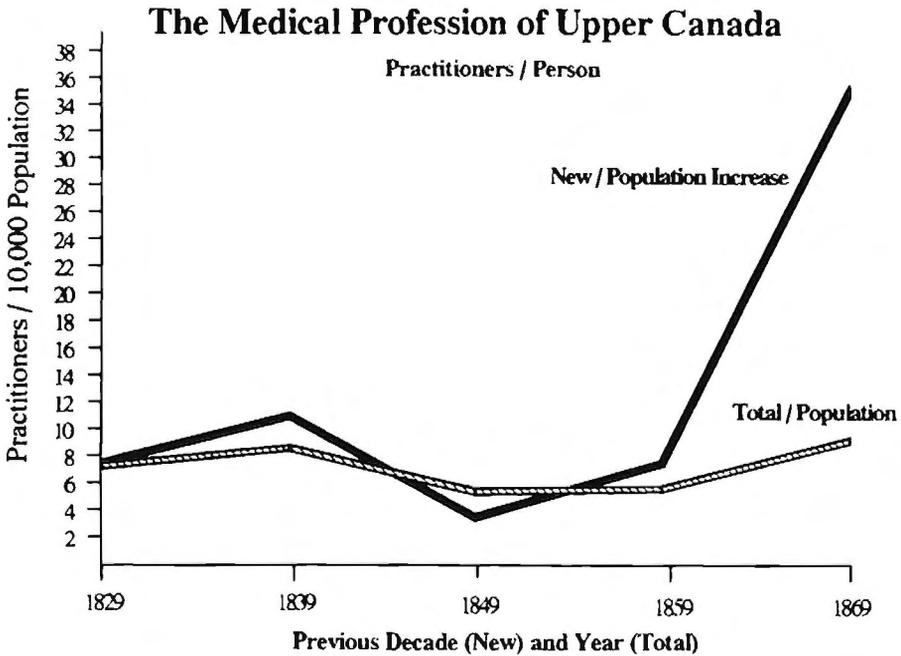


Figure 2 For sources, see notes 11 and 15.

Medical Legislation and its Context

Before 1850

A bill creating the Upper Canada Medical Board, which was to examine and license all medical practitioners who were not automatically permitted to practice, was passed in 1815.¹⁶ The first board met in 1818 but, in fact, almost all practitioners were exempt from licences. In 1827 a new act was passed that required all doctors to be licensed. Those previously exempt — military surgeons, physicians with British degrees, long-time practitioners, and doctors with English qualifications — could receive licences upon application; the rest had to present themselves to the board for examination.¹⁷ This act was to

16 The medical legislation of this period has been discussed by other historians. Sources for this discussion were Elizabeth MacNab, *A Legal History of the Health Professions in Ontario* (Toronto: Queen's Printer, 1970); Gidney and Millar, "The Origins of Organized Medicine", pp. 65–95; the *Journals of the Legislature of Upper Canada*; and the *Journals of the Legislature of the Province of Canada*.

17 Anyone formerly exempted was required to present the necessary diploma, commission, or licence to a district judge and swear that he was the person named in the document in question. The grandfather clause was updated to allow any practitioner who had practised "before and during the late war" (the War of 1812) to be licensed after swearing to that effect and obtaining the signed testimony of three licensed practitioners that he was competent to practise. No doctor granted a licence under the old act applied for a new one; otherwise all of the above criteria were utilized by different practitioners. See NAC, *Medical Board Certificates and Reports on Candidates for Medical Licenses with Supporting Documents*, RG5 B9, v. 61–68. 1819–1854.

remain in effect until 1865. (Another act created a College of Physicians and Surgeons in 1839, but it was vetoed by Queen Victoria at the request of the Royal Colleges in London, which felt it infringed on their rights.)

In Ontario most practitioners held the physical disequilibrium view of the body which required active intervention during illness.¹⁸ The treatments were standard ones such as bleeding for fevers, blistering as a counter-irritant, and strong purges. These procedures were prescribed by those known as allopathic or regular practitioners, the only ones eligible for licences.¹⁹ The other irregular sects were the Thomsonian, the eclectic, which was first closely associated with the Thomsonian, and the homeopathic.²⁰

Thomsonians had tended to be more rurally based "root doctors". "Eclectics" substituted that name for the original "Thomsonian" to indicate the

determination of the Society to seek medical knowledge from every available source, and to select from any and every other System whatever has been practically demonstrated to be safe and efficient in the cure of disease; thus uniting freedom of inquiry with stability of principle and purpose.²¹

In other words, eclectics sought to incorporate all "satisfactory" principles and practices from other medical groups, both regular and irregular, into their education and practice.²² Homeopaths treated symptoms with extremely dilute solutions of substances that in a stronger dose would produce the same symptoms.

As their numbers increased, physicians, like other professionals, began to feel that their traditional power in the community was being eroded. In the opinion of physicians in Ontario, two classes of practitioners negatively

18 Gidney and Millar, "The Origins of Organized Medicine", p. 66.

19 For a discussion of therapeutics in this region, see Jacalyn Duffin, "A Rural Practice in Nineteenth-Century Ontario: The Continuing Medical Education of James Miles Langstaff", *Canadian Bulletin of Medical History*, vol. 5 (1988), pp. 3-28; and Duffin, *Langstaff*. See also James Thomas Hamilton Connor, "To Be Rendered Unconscious of Torture: Anaesthesia in Canada, 1847-1920" (M.Phil. thesis, University of Waterloo, 1983). For a brief discussion of the end of the 1860s, see James Thomas Hamilton Connor, "Joseph Lister's System of Wound Management and the Canadian Medical Practitioner, 1867-1900" (M.A. thesis, University of Western Ontario, 1980); J. T. H. Connor, "Listerism Unmasked: Antisepsis and Asepsis in Victorian Anglo-Canada", *Journal of the History of Medicine and Allied Sciences*, vol. 49 (1994), pp. 207-239.

20 J. T. H. Connor reported in "Minority Medicine" that "minority medicine" consisted of female midwives, commercial vendors of medicines, domestic or lay healers, and sectarian practitioners (p. 1). There were several sectarian groups in Ontario: Thomsonians, hydropaths and other water therapists, phrenologists, eclectics, and homeopaths (p. 190). See also J. T. H. Connor, "'A Sort of *Felo-de-se*'", pp. 503-527, for a discussion of eclecticism and homeopathy during this period; see Gidney and Millar, "The Origins of Organized Medicine", pp. 68-69, for a discussion of the various medical sects. Connor disagrees with their account on several points (see, for example, p. 507).

21 NAC, Provincial Secretary's Correspondence and Correspondence Register, Canada West; NAC, RG5 C1, v. 314, file 39, Petition to Governor General of John G. Booth, President, Canadian Eclectic Society, 1851.

22 J. T. H. Connor, "'A Sort of *Felo-de-se*'", pp. 504-505.

affected the status of their profession: the so-called “quacks” and, from the forties onward, unfit medical graduates from local schools.²³

Physicians regularly complained about incompetent practitioners who were bringing the profession into disrepute. In 1820, James Sampson complained of two unlicensed practitioners at Queenston.²⁴ James Muirhead wrote with Dr. Telfer to the Attorney General in 1832 to protest the prevalence of “Empirics, licensed or not” and to demand legislation.²⁵ Darius Johnson petitioned the Lieutenant Governor in 1835 to revoke Patrick McMullen’s licence on a technicality because of “the unfortunate manner the said Patrick McMullen has treated his patients”.²⁶

A letter from the physician Cyrenius Hall in 1836 revealed less altruistic motives. Hall wrote:

I have the honour to inform you ... that there are now in this country many impostors practicing Physic and Surgery who stile [*sic*] themselves Licentiates of the Province and thus impose upon the credulous community and prevent the settlement of those justifiably entitled to the same.

Hall went on to demand action from the government. A government official wrote on the letter, “If this request should be complied with who would defray the expense?”²⁷ This illustrates the reality of medical licensing in this era. The licensing legislation was taken seriously and applied strictly in most cases.²⁸ Certainly, many practitioners perceived licences to be necessary — many who were denied licences on the basis of their credentials later appeared before the board at great expense and inconvenience in order to obtain them.²⁹ But there was never any real penalty for being un-

23 Gidney and Millar, “The Origins of Organized Medicine”, p. 67.

24 Canniff, *The Medical Profession*, pp. 610–615.

25 *Ibid.*, pp. 527–528. Ironically, in 1829 T. Raymond had officially enquired if James Muirhead had a medical licence; the answer was that he had not. NAC, Medical Certificates, RG5 B9, v. 62, pp. 260–262. No action appears to have been taken, nor does it appear that Muirhead ever took out a licence although he was certainly eligible, having practised “before and during the late war”.

26 NAC, Medical Certificates, RG5 B9, v. 63, pp. 648–649, Letter of Darius Johnson, 1835.

27 NAC, Medical Certificates, RG5 B9, v. 63, p. 655, Letter of Cyrenius Hall with Note, 1836.

28 For example, Alexander Wylie, who had a diploma from the Faculty of Physicians and Surgeons of Glasgow, was refused a licence and sat the exam. See NAC, Medical Certificates, RG5 B9, v. 61, pp. 114–115 and 135–136, 1827. However, occasionally the rules were bent. Patrick Wharrie, who did not have a commission for his army service but rather a letter stating that he had been examined before an Army medical board, received a licence after C. Widmer, President of the Upper Canada Medical Board, intervened on his behalf. This led the Attorney General to give as his opinion that the “intent” of the act, which was to keep the unqualified from practising, allowed for this exception, despite numerous other cases like Wylie’s, in which practitioners were informed that “the Act leaving no discretion whatever”, they had to appear before the board. NAC, Medical Certificates, RG5 B9, v. 62, p. 585–595, 1834.

29 For examples, see the letters of J. McCague and J. Stratford, NAC, Medical Certificates, RG5 B9, v. 61, pp. 128–130, 139–140, and v. 62, pp. 478–479, 504–505.

licensed.³⁰ This lack of enforcement was the profession's rationale for supporting each successive piece of legislation. Hall wrote in 1836 about the unsatisfactory situation, but as early as 1826 an anonymous columnist, "Medicus", had called for a new Medical Act to encourage educated medical men and to protect the public from quacks because the previous act had never been enforced.³¹ The preface of the vetoed act of 1839 stated:

[I]t is highly desirable that the profession of medicine in this Province should be placed on a more respectable and efficient footing and that a more summary mode should be provided for the conviction and punishment of persons practicing without a license.

There are several possible explanations for the significant decrease in the number of doctors per capita in the 1840s (see Figure 2). It could be merely an artifact of my data sources. The 1840s were unsettled in Upper Canada because of the effects of the failed Rebellion of 1837, which eventually led to the 1841 Act of Union. The organized medical profession was especially affected because a number of prominent professional leaders had been involved in the Rebellion, initially fled to the United States, and then began returning in the mid-1840s. Queen Victoria's veto of the act of 1839, after its implementation in the colony, also created some administrative confusion. As well, there is evidence that the Upper Canada Medical Board, disappointed by the refusal of the 1839 act, applied much stricter standards in its examinations through the 1840s.³²

After 1850

Physicians continued to place their hopes for professional elevation in legislation, however. In 1851 the regular profession petitioned for incorporation, a status already achieved by its counterpart in Quebec. Physicians wanted to "enjoy equal advantages with their brethren" in Quebec and to be able to "raise the standard of education and by such means secure the confidence of the public".³³ A similar petition in 1858 stressed that, for the "safety of the Inhabitants of this section of the Province", action had

30 I have come across one exception. Henry Taylor petitioned for a licence in February 1831; the petition was denied. NAC, Medical Certificates, RG5 B9, v. 62, p. 391-394. Later Taylor was "hauled up for practicing without a license, but the validity of his English diploma was maintained, and he was acquitted". Canniff, *The Medical Profession*, p. 646. The date is not noted; however, the context suggests this happened in the 1860s, although it could have occurred later since Taylor was still practising in the 1890s.

31 PRO, CO 47.56, "Medicus", *The Upper Canada Herald*, Kingston, November 14, 1826, p. 35.

32 See Canniff, *The Medical Profession*, pp. 192-198; and Hamowy, *Canadian Medicine*, p. 42.

33 NAC, Provincial Secretary's Correspondence, RG5 C1, v. 355, file 1452, Petition to Lord Elgin by practitioners of Upper Canada, 1852.

to be taken to ensure that practitioners had acquired "sufficient Medical and Surgical Education".³⁴

In the 1850s and 1860s charges of incompetence had a more particular focus as the number of homeopathic and eclectic practitioners expanded.³⁵ It is important not to accept the regular practitioners' stigmatization of their contemporaries as "quacks": a patient was much safer and more comfortable in consulting a "quack" whose therapy was comparatively non-interventionist than in seeing a regular physician. The eclectics, for example, "repudiate[d] blood-letting and the use of poisonous substances in common medication".³⁶ This difference no doubt helped the irregulars to gain many patients. Also the irregulars did not reject science. The eclectics claimed that their treatments were in the spirit of free enquiry and even used the term medical science to describe their studies.³⁷

It is not clear how many irregulars practised in this period.³⁸ My research suggests that the eclectics and homeopaths made up a small proportion of the total profession, with three per cent being homeopathic and six per cent, eclectic. They probably appeared to be a stronger threat, however, since they were increasing in number. The sectarians comprised a more significant proportion of entering practitioners: new doctors were about five per cent homeopathic and 11 per cent eclectic. These irregulars had a strong following and were well organized: they mounted petition drives which defeated all incorporation bills excluding them between 1845 and 1859.³⁹

These incorporation bills were also a response to the local schools of medicine and the associated plots and counterplots among various groups in the profession. In rough outline these intrigues involved two main factions. The first was the establishment, Tory, Anglican group — its members were on the Medical Board and the Faculty of the University of Toronto. The second group was headed by John Rolph, the former Reformer who had returned from exile in the United States. In 1853 Rolph emerged triumphant when Premier Hincks closed the University of Toronto medical school (the main competition for Rolph's school) in exchange for support of various

34 NAC, Provincial Secretary's Correspondence, RG5 C1, v. 1098, 1858.

35 In the mid-1840s and early 1850s, homeopathy was not as significant as Thomsonianism in Ontario. J. T. H. Connor, "Minority Medicine", pp. 404–405. By the 1850s there was also a move from Thomsonianism to eclecticism. *Ibid.*, p. 364.

36 NAC, Provincial Secretary's Correspondence, RG5 C1, v. 314, file 39, Petition, Canadian Eclectic Society, 1851.

37 See NAC, Provincial Secretary's Correspondence, RG5 C1, v. 810, file 897, 1865, and v. 314, file 39, 1851.

38 Jennifer J. Connor reported that there were few sectarian writers or editors in Canada. The majority were homeopaths who wrote pamphlets in Ontario until about the 1870s. Thomsonians reprinted texts from American sources, with the exception of one serialized pamphlet campaign, and eclectics produced very little. Jennifer J. Connor, "To Advocate, to Diffuse, and to Elevate", p. 328 and pp. 69, 71–72.

39 Gidney and Millar, "The Origins of Organized Medicine", p. 74.

government measures.⁴⁰ James Henry Richardson, a contemporary antagonistic to Rolph and Hincks, charged that Rolph had supported the Hincks government in order to gain control of the Lunatic Asylum and the General Hospital and to annihilate the university medical school.

Although Rolph was victorious in 1853, it is clear that the establishment group had previously attempted to consolidate its own power by keeping him and others out of the medical profession's ruling bodies. The Medical Board and the University of Toronto medical school were virtually synonymous, since in 1845 the professors of the university had been added to the board.⁴¹ By the early 1850s there were wide suspicions that the Medical Board favoured university medical students in the exams.⁴² Before Rolph's coup, the board had controlled the Toronto General Hospital⁴³ and the

40 This account is partially drawn from Richardson, "Reminiscences of the Medical Profession in Toronto". Dr. Richardson outlined events as the establishment group would have viewed them. The University of Toronto medical school was operating successfully when, in the session of 1852-1853, "came, like a bolt out of a clear sky, an act of the legislature abolishing the Faculties of Medicine and Law. The alleged reason for this was the clap-trap one, that no public funds should be appropriated to teach the professions. The real reason was to crush the opposition to Rolph's private school." Richardson surmised that the government took this course in order to reconcile with the former supporters of the aborted Rebellion, a necessary move to carry out government policy in other areas. Richardson then continued, "The animus of the Bill was shewn in ... a clause that provided that it would not be lawful for any person or anybody to *endow* any chair in the University in any branch of Medical Education, or in *any subject allied* thereto. ... [T]he Governor in Council was empowered to select such Medical Schools as he saw fit, to be affiliated with the University, for the examination of Medical Degrees. ... [T]he Toronto School of Medicine [at that time Rolph's school] was so chosen."

41 Correspondence with regard to the members of the Board confirms the addition of the professors as well as other gentlemen. NAC, Medical Certificates, RG5 B9, v. 63, pp. 929-934.

42 In 1851 a question was asked in the legislature about the composition of the Medical Board and the relation of its members to the university. The questioner further demanded to know where recent candidates for Board examinations had been educated and what their fates in the exams had been. Certainly four students at the Toronto School of Medicine felt that the exams were not impartial and they refused to sit the exams unless they were held publicly (which the board refused to do). The breakdown produced in response to the question posed in the legislature does not substantiate the students' allegations but it indicates that their suspicions were widely held. Since all four Toronto School of Medicine students who sat the exam passed, the students' slur does not hold up. But of the 20 students who passed, eight had studied at least in part at the university. The fact that four of these students had previously studied at comparable schools elsewhere suggests that it was at least believed that a course of study at the university assisted a medical student in passing the board exam. The entire correspondence and statistics can be found in the *Journals of the Legislative Assembly of the Province of Ontario*, vol. 10, May 20 — August 30, 1851 (14 & 15 Vic.), pp. 83-84. See also NAC, Provincial Secretary's Correspondence and Correspondence Register, Canada West, RG5 C1, v. 327, file 887, 1851, for letters from the Legislative Assembly to the Governor General asking first for a list of members of the Medical Board, distinguishing those that were also professors at the university, and second for the number of persons examined and passed by the board including their place of education.

43 See NAC, Provincial Letterbook, 1846-1847, RG5 C2, Reel C-13142, Letter 197, for a complaint that non-University of Toronto students were experiencing difficulty gaining access to the hospital. The letter that appointed the professors to the Medical Board also appointed the Trustees of the Toronto General Hospital. NAC, Medical Licenses, RG5 B9, v. 63, pp. 929-934.

Toronto Lunatic Asylum.⁴⁴ In the end Rolph's triumph was short-lived. Soon after he quarrelled with his own faculty, and a new series of feuds and plots ensued.

The hospital remained a continuing centre of disputes. The proprietary Toronto School of Medicine complained about the condition of the hospital, the favours given to Anglicans, and the negligence of the teaching staff in 1855.⁴⁵ That same year the Victoria University Medical School's complaint that cadavers were mutilated so as to be useless for instruction before being forwarded to the school was received sympathetically; their complaint (repeated in 1862) that the hospital was dominated by staff from the Toronto School of Medicine was ignored.⁴⁶ The operation of the Medical Board also remained controversial. In 1864, the Legislative Assembly asked the Provincial Secretary for all correspondence with respect to the Medical Board since 1860 and a list of its members including their medical school affiliation.⁴⁷

The negative public image of the profession generated by all this highly publicized infighting had been exacerbated by an incident in 1855 when two hospital patients were killed by a morphine overdose administered by two medical students from different local schools.⁴⁸ This must have bolstered the general belief that the Toronto medical schools, like other proprietary schools, were motivated by a desire for profit rather than public interest. Their matriculation and graduation standards were perceived to be low. More importantly their affiliation with universities meant that their graduates, no matter how poorly trained, were automatically licensed to practise medicine.⁴⁹

The growing number of medical graduates and their presumed dubious quality led practitioners and the public to call for legislation to eliminate the danger to the public and the profession. The aims of the public and physicians, while not in direct conflict, did not coincide. The public wanted unsafe practitioners to be barred from practice, but also wanted to be able to consult eclectic

44 The asylum question is much more complex and was the subject of government investigation. See appendices N, FFF, and GGG to the *Journal of the Legislative Assembly of the Province of Canada*, 1849.

45 See NAC, Provincial Secretary's Correspondence, RG5 C1, v. 445, file 959, 1855.

46 See NAC, Provincial Secretary's Correspondence, RG5 C1, v. 644, file 1575, 1858, and v. 721, file 1262, 1862. To further confuse the issue, Rolph, originally of the Toronto School of Medicine, was now on the faculty of Victoria College. Victoria College was still having problems obtaining bodies from the Toronto General Hospital (see file 93, 1860).

47 NAC, Provincial Secretary's Correspondence, RG5 C1, v. 779, file 788, 1864.

48 Gidney and Millar, "The Origins of Organized Medicine", p. 70; see also Jacalyn Duffin, "In View of the Body of Job Broom: A Glimpse of the Medical Knowledge and Practice of John Rolph", *Canadian Bulletin of Medical History*, vol. 7 (1990), pp. 9-30.

49 See R. D. Gidney and W. P. J. Millar, "The Reorientation of Medical Education in Late Nineteenth-Century Ontario: The Proprietary Medical Schools and the Founding of the Faculty of Medicine at the University of Toronto", *Journal of the History of Medicine and Allied Sciences*, vol. 49 (1994), pp. 52-78. Although the main focus of this paper is after 1870, the authors do comment on the period before 1870.

Geographic Distribution of Educational Institutions

Attended by New Practitioners 1820 - 1870

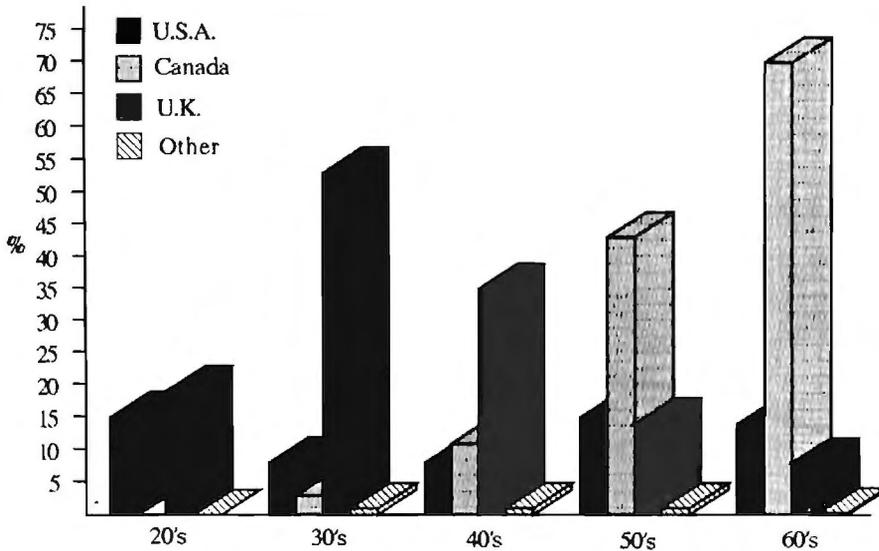


Figure 3 For sources, see note 11.

or homeopathic practitioners. The physicians wanted to bar unsafe practitioners, and they considered all irregulars unsafe or at least unfit to practise. The result was that the series of bills between 1845 and 1859 were defeated by either public or professional pressure.⁵⁰

A similar debate in the United States over the educational standards and the legitimacy of unorthodox sects resulted in the repeal of all medical licensing legislation. This solution mustered some support in Ontario; in 1851 a bill to abolish all licensing was defeated by only one vote. But it went against the grain of Ontario to emulate the United States in any manner. Indeed, most of the previous licensing legislation had specifically denied American MDs an exemption from board exams in order to discourage the men of Ontario from studying medicine at American schools, where they might be influenced by the evils of republicanism.

Figure 3 clearly illustrates that a negligible number of Ontario practitioners in this period had attended centres of medical education outside the United States, Great Britain, and Canada (Canadian schools in this era were located in Ontario and Quebec). As well, surprisingly few practitioners had

⁵⁰ See the discussion in Gidney and Millar, "The Origins of Organized Medicine", pp. 71-77.

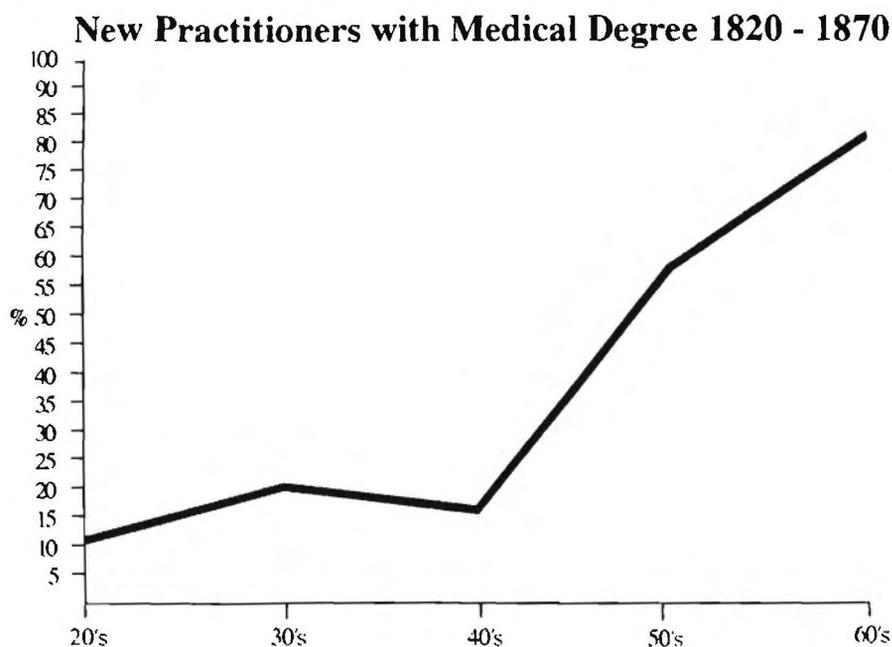


Figure 4 For sources, see note 11.

attended American medical schools, and the percentage of new practitioners from American schools remained roughly constant. The figures attest to the success of the Ontario elite's policy of discouraging young men from travelling to the United States for a medical education. This policy was effected by the licensing legislation, which never recognized American degrees, but also by the establishment of local medical schools in the 1840s, at the point when there were enough locally-born young men to be tempted by the proximity of the American schools.⁵¹ With the establishment of local schools in Ontario and the growing reputation of McGill in Quebec, the numbers educated in Canada increased as the numbers educated in the United Kingdom decreased.

Figure 4 illustrates that, throughout this period, increasing numbers of practitioners chose to complete the MD degree before beginning practice. Initially doctors had been trained mainly through apprenticeship. They attended lecture courses, either to fulfil the requirements to sit one of the British licensing exams or to increase their chances of passing the local exam. By the 1860s most practitioners chose to complete a degree programme rather than merely attend lectures in conjunction with an appren-

⁵¹ Canniff, *The Medical Profession*, pp. 53, 176.

ticeship; these graduates were also automatically licensed for practice.⁵² J. T. H. Connor has argued that the apprenticeship system had fostered individualism and that a medical school education fostered a "greater sense of collective identification" among physicians and led to a "more homogeneous profession".⁵³ Although a medical degree was never required for practice, by the 1860s the cachet of an MD had become important. In the 1850s and 1860s, many long-time practitioners obtained their first medical degree.⁵⁴

Both the general public and medical profession agreed that action needed to be taken to raise the standard of practising physicians, but there was no consensus about what action was appropriate. The proposed bills of the 1850s had failed because they lacked the support of either the profession or the public.⁵⁵ Factionalism between schools, cities, and types of practitioners kept doctors from supporting any legislation effectively. Although the American solution was rejected, partially because of social conservatism and anti-American feeling in Upper Canada,⁵⁶ Ontarians wanted the freedom to choose their own practitioners. The general public was unwilling to accept any solution that did not include the irregulars.⁵⁷

This public sentiment, together with the lobbying of the irregulars' organizations, resulted in the bills of 1859 and 1861, which created two more medical boards: the Eclectic and Homeopathic Licensing Boards. These acts differed from that of 1827 (which had created the original board) by requiring candidates to have completed four years of medical studies, with at least two in a medical school, and by having the boards elected by their members rather than appointed by the Governor. This left allopaths with licensing requirements clearly less stringent than those of the irregulars and the implied insult of having an appointed board while the irregulars had an elected one.

An important factor for practising physicians was that the number of new practitioners as compared to the increase in population more than quadrupled

52 The Upper Canada Medical Board encouraged this trend from as early as 1830, when it rejected a candidate on the grounds that he had no proof of attending lectures. *Ibid.*, p. 58.

53 J. T. H. Connor, "Minority Medicine", p. 229 and pp. 214-217.

54 The practitioner James Langstaff, for example, had always written the letters MD after his name and finally obtained the degree in 1876. Duffin, *Langstaff*, p. 31.

55 See Gidney and Millar, "The Origins of Organized Medicine", pp. 71-77.

56 See S. F. Wise and R. C. Brown, *Canada Views the United States* (Toronto: Macmillan of Canada, 1967), for a discussion of these attitudes; J. T. H. Connor, in "Minority Medicine", discusses the connection between anti-quack and anti-American sentiment (pp. 206-207).

57 As a medical journal in 1852 rather bitterly described the situation, "hordes of root doctors, steamers, and quacks that are flocking into every village in Upper Canada and dividing with the regularly qualified physician the scanty subsistence the practice of the neighbourhood is capable of affording, these impostors ingratiate themselves into the good opinion of the farmers and country shopkeepers, and descend to familiarities with the lower classes, to which the educated gentlemen cannot stoop, and soon the latter finds that his ignorant and low competitor is preferred to himself." *Canadian Medical Journal*, vol. 1 (1852), p. 313, quoted in Hamovy, *Canadian Medicine*, n. 98, p. 328.

in the 1860s (see Figure 2).⁵⁸ Although the number of practitioners per capita was still relatively stable, this sudden increase indicated that the unease practitioners felt was not unwarranted. The trend was towards a profession that would quickly become overcrowded, rendering it difficult or impossible for a physician to make a living. There is evidence that successful, established physicians had modest incomes from practice during this period.⁵⁹ The fear of diminishing incomes in the face of growing numbers of practitioners gave the regular profession the impetus to support the legislation of 1865 and 1869. It is probably not coincidental that the aborted act of 1839, which the medical profession supported, followed an earlier period in which the number of practitioners increased much more rapidly than the population.

This dramatic increase in numbers relative to population was true not just for physicians but for the entire category of what the census takers referred to as the "professional classes". From 1861 to 1871 the numbers in this class rose from 9,438 to 16,759, with physicians (according to the census) constituting the same percentage of the professional group in both counts.

The regular practitioners had been discontented about the state of the profession for decades. The legalization of the irregulars and their own increasing numbers certainly only increased this discontent. Regulars also feared that the public feuds of the schools were eroding their social position.⁶⁰ These factors and the precedent of the British act of 1858 led to their support of the legislation that would result in the formation of the College of Physicians and Surgeons of Ontario in 1869.

The College had undisputed control over both matriculation requirements and licensing examinations but no power to police the schools. There were to be no exemptions for exams (except for those already licensed).⁶¹ Amendments to the 1869 act repealed the bills of 1859 and 1861 and granted the irregulars full membership in the College. With this act, the medical profession in Upper Canada gained a clear organizational structure and was granted a legislative monopoly.

The public still felt it had the freedom to choose among various types of practitioners. Regular physicians were unhappy that the irregulars were granted an equal professional status, but had accepted their entry into the

58 This was also noted by Gidney and Millar, "The Origins of Organized Medicine", p. 78. Duffin, in *Langstaff*, reported that Langstaff's daybooks tend to confirm that the Ontario medical profession was crowded by the 1860s. In particular, doctors whose names were mentioned in the 1860s were "far more likely to leave the profession than those who came before or after" (p. 32).

59 See Charles G. Roland and Bohadar Rubashewsky, "The Economic Status of the Practice of Dr Harmaunus Smith in Wentworth County, Ontario, 1827-67", *Canadian Bulletin of Medical History*, vol. 5 (1988), pp. 29-49; and Duffin's account of Langstaff's finances, *Langstaff*, pp. 46-58.

60 Gidney and Millar, personal communication. I thank R. D. Gidney and W. P. J. Millar for supplying me with a draft of forthcoming work.

61 All regulars in continuous practice in the province since 1850 could register if they had attended at least one course of lectures; all homeopaths and eclectics could register if they had practised in Ontario for the previous six years upon the recommendation of their College representatives.

College so that the bill would pass. Physicians were pleased the bill gave them a monopoly on medicine, which soon resulted in fewer graduates from the medical schools. The public was assured that it had avoided the dangers of the American situation.⁶²

Although the inclusion of the homeopaths and eclectics in the College had been viewed by the regular profession as a necessary evil, the regulars could not have devised a more painless method to eradicate the "quacks". As a minority group, the eclectics and homeopaths had limited power, and they were slowly eliminated by educational requirements set by the majority.⁶³ The historian J. T. H. Connor has convincingly argued that "The eventual absorption of Eclectic physicians into mainstream medicine was the conscious decision of the Eclectics themselves."⁶⁴ Nonetheless, the joint licensing board facilitated this later absorption — an eventuality that legislators had not officially anticipated.

The situation did not change immediately in 1869.⁶⁵ Unregistered practitioners continued to practise, and, although the College appointed a public prosecutor in each territory to enforce the act, the courts were lenient. Also, approximately 500 practitioners licensed under former acts refused to register; they claimed that their licences were still valid, or rejected a College that included the irregulars.⁶⁶

Comparison with Quebec

In the nineteenth century, the population of Quebec was essentially rural, francophone, and Catholic.⁶⁷ Francophones dominated politics, and, in the second half of the century, the medical profession itself became majority francophone.⁶⁸ Despite this linguistic separation, there were similarities between Quebec and Ontario. In Quebec, as in Ontario, the practice of medicine was never unregulated. Quebec practitioners also had direct political influence; there were significant numbers of physician-politicians at both the local and provincial levels.⁶⁹

Most Quebec doctors were trained by apprenticeship before 1850; those who had been formally educated had studied mainly in European or Ameri-

62 Gidney and Millar, "The Origins of Organized Medicine", pp. 86–87.

63 This eventuality had been anticipated both by supporters of the homeopaths and eclectics, who strongly opposed an 1865 act that proposed to leave the irregulars in a minority position on a medical governing council, and by opponents of the irregulars, who were quick to see their opportunity after the enactment of the 1869 act. Gidney and Millar, personal communication and "The Origins of Organized Medicine", p. 87.

64 J. T. H. Connor, "A Sort of *Felo-de-se*", p. 504.

65 In 1869 many long-standing practitioners registered for the first time.

66 Macnab, *A Legal History*, p. 17.

67 Bernier, *La médecine au Québec*, p. 9.

68 *Ibid.*

69 *Ibid.*, pp. 11 and 161.

can medical institutions.⁷⁰ By the 1880s, nearly 90 per cent of practitioners had been trained by a provincial medical school. While many McGill graduates later practised in Ontario,⁷¹ no Ontario medical school attracted a similar number of Quebec-bound practitioners. A licence was also desirable for medical practitioners in Quebec. McGill managed to attract many francophone students, even in the face of linguistic, cultural, and religious barriers, because it was the only Quebec medical school whose degree-holders were automatically licensed.⁷² The Quebec profession appears to have been significantly less crowded than that in Ontario, although, as in Ontario, the number of practitioners relative to the population remained stable through the period with an increase in the 1860s.⁷³

The most visible difference between the medical professions in Ontario and Quebec was the successful establishment (much envied by many Ontario practitioners) in 1847 of the Lower Canada College of Physicians and Surgeons. The College was given the power to regulate the study of medicine in Quebec. This development of a formal college was far in advance of any similar development in Ontario (1869), Britain (1858), or the United States (see discussion below). It is important not to overstate this difference, however, since a College of Physicians and Surgeons had been created by the legislature of Ontario in 1839, only to be later disbanded after the legislation was vetoed by the Queen.

The historian Jacques Bernier has suggested that the power vacuum that emerged in Quebec with the British takeover of New France gave the professions generally a more important role. The Quebec medical profession, due in part to the influence of Paris in the early nineteenth century, was more unified than in other parts of North America. In particular, irregular practitioners such as homeopaths and eclectics played little role in the province. Bernier ascribed the social conservatism of Quebec, reflected also

70 George Weisz, "The Geographical Origins and Destinations of Medical Graduates in Quebec, 1834-1939", *Histoire sociale/ Social History*, vol. 19, no. 37 (May 1986), pp. 93-119, p. 94, reprinted in French translation as "Origines géographiques et lieux de pratique des diplômés en médecine au Québec de 1834 à 1939", in Marcel Fournier et al., eds., *Sciences et médecine au Québec : perspectives sociohistoriques* (Quebec: IQRC, 1987), pp. 129-170. Weisz is quoting from a paper presented by Barbara Tunis in 1983 to the *Séminaire interuniversitaire sur l'histoire de la médecine au Québec*.

71 Weisz, "The Geographical Origins", p. 103.

72 *Ibid.* After 1871 the number of francophone students diminished because there were recognized French degree-granting institutions in the province.

73 The figures for doctor per persons below are from Bernier, *La médecine au Québec*, Table 7, p. 11. I have adjusted them to represent doctors per 10,000 persons so that they may be compared with Figure 2.

| | | | | |
|----------------|------------|------------|------------|------------|
| Year | 1831 | 1851 | 1861 | 1871 |
| Doctor/persons | 1/2,577 | 1/2,389 | 1/2,719 | 1/2,182 |
| Doctors/10,000 | 3.9/10,000 | 4.2/10,000 | 3.7/10,000 | 4.6/10,000 |

in a regulated rather than free medical market, to Catholicism rather than to anti-Americanism as in Ontario.⁷⁴

Comparison with the United States and Great Britain

In London, until the Medical Act of 1858, the key to the structure of the early nineteenth-century medical profession was the separation of medical men into three orders — physicians, surgeons, and apothecaries.⁷⁵ Outside London, however, the licensing bodies associated with each branch of the profession had little relevance. Few practitioners could afford the luxury of confining their practice to one branch of medicine, and the “general practitioner” was commonplace.⁷⁶ The situation in nineteenth-century Ontario was more akin to the provincial. Although the Upper Canada Medical Board attempted to maintain some distinctions between surgeons, midwives, and physicians,⁷⁷ separate branches of medicine never really existed. In Britain the 1858 act was controversial because it did not distinguish between types of practitioners; in Ontario the division of practitioners was never an issue in devising legislation. In both regions the formal educational requirements of the profession increased during this period.⁷⁸

In Ontario and Britain regular practitioners campaigned vigorously but ineffectively against “quack” practitioners.⁷⁹ The failure of both campaigns was due to popular support for the irregulars.⁸⁰ In Britain the 1858 act abolished the corporation monopolies and set up a Medical Register, but practitioners not listed on the register could not be prosecuted. The unregistered could not hold government or military medical positions, sue for fees, or call themselves “physicians”, “surgeons”, “apothecaries”, or “doctors”, but otherwise their right to practise was clear.⁸¹ The Ontario act was more restrictive in intent (although not in effect, as prosecution was unlikely), as it allowed for prosecution of unregistered practitioners.

Despite its geographical proximity, the Ontario medical profession had less in common with its counterpart in the United States. Throughout this period Ontario had a less crowded profession than much of the United States. For example, there were fewer practitioners per capita in Ontario

74 See the discussion in Bernier, *La médecine au Québec*, pp. 161–163.

75 Peterson, *The Medical Profession in Mid-Victorian London*, pp. 5–6.

76 Hilary Marland, *Medicine and Society in Wakefield and Huddersfield 1780–1870* (Cambridge: Cambridge University Press, 1987), pp. 264–266.

77 There are numerous instances of the board granting licences to practise only “surgery” or “midwifery” and, when these practitioners were incorrectly gazetted for all branches (as they often were), C. Widmer, President of the Board, would correct the error. See, for example, NAC, Medical Licenses, RG5 B9, v. 68, pp. 1163–1169, Widmer’s letter, April 4, 1854.

78 Peterson, *The Medical Profession in Mid-Victorian London*, p. 62; Marland, *Medicine and Society*, p. 267.

79 Marland, *Medicine and Society*, p. 322.

80 *Ibid.*, p. 326.

81 Ramsey, “The Politics of Professional Monopoly”, p. 248.

than in Rochester, New York, located in a comparable region. (Up-state New York was also virtually unsettled by Europeans before the nineteenth century.)⁸² Unlike in Britain and Canada, the educational standard in Rochester decreased from 1811 to 1860.⁸³ In the United States during this period, most legislative control of practice was abolished.⁸⁴ Typically the regular profession of Rochester supported the abolition of licensing rather than allow irregulars to be licensed.⁸⁵ The increased mobility of practitioners in Rochester was a response to the difficulties they faced and contributed to the social decline of the profession. Physicians had to move in search of new areas in which to practise, so there was little continuity in the medical community. Indeed, in Rochester medical practitioners ceased to be community leaders,⁸⁶ while in Ontario, particularly in Toronto, there was a long, unbroken tradition of physician-politicians. Events in Rochester would certainly have supported the contemporary contention that the province of Ontario had avoided the evils of the American situation. Rochester followed the same pattern as Ontario about 40 years later: from 1860 to 1910 educational requirements were re-established and then gradually raised.⁸⁷

A striking difference between physicians in Ontario and the United States is that so few Ontarians studied in Paris. (In Figure 4, the negligible column "others" includes those who had studied in Paris.)⁸⁸ Americans had gone to Edinburgh in large numbers during the eighteenth century, a period when there were few local medical schools.⁸⁹ In the nineteenth century, although large numbers continued the trek to Edinburgh, Paris had become the new medical Mecca, particularly for elite practitioners. Sir William Osler's statement about Canadian medicine that "the Paris influence, less personal was chiefly exerted through English and Scotch channels"⁹⁰ held true for

82 See Edward C. Atwater, "The Medical Profession in a New Society, Rochester, New York, 1811-1860", *Bulletin of the History of Medicine*, vol. 45 (1973), pp. 221-235, and "The Physicians of Rochester, New York, 1860-1910: A Study in Professional History, II", *Bulletin of the History of Medicine*, vol. 51 (1978), pp. 93-106. The trends in Rochester are typical of the United States generally. See J. F. Kett, "American and Canadian Medical Institutions, 1800-1870", *Journal of the History of Medicine and Allied Sciences*, vol. 20 (1967), pp. 343-356.

83 Atwater, "The Medical Profession in a New Society", p. 223.

84 Ramsey, in "The Politics of Professional Monopoly", stated that though "some remnants of a licensing system remained, the American medical field was the freest in the Western world" (p. 251).

85 Atwater, "The Medical Profession in a New Society", pp. 226, 233.

86 *Ibid.*, p. 233.

87 Atwater, "The Physicians of Rochester", p. 93.

88 John H. Warner, *The Therapeutic Perspective* (Cambridge: Harvard University Press, 1986), p. 186.

89 See J. Rendall, "The Influence of the Edinburgh Medical School on America in the Eighteenth Century", in *The Early Years of the Edinburgh Medical School* (Edinburgh: Royal Scottish Museum, 1976), pp. 95-127, for a discussion of American medical students travelling to Edinburgh.

90 W. Osler, "British Medicine in Greater Britain", in *Aequanimitas*, 2nd ed. (London: H. K. Lewis & Co. Ltd., 1906), p. 182.

Ontario. Canadian-born practitioners were frequently trained in Edinburgh during this period. For instance, Thomas Macklem, an Ontario practitioner, was Scottish-trained and noted for his use of the stethoscope, an invention of the Paris school.⁹¹

Perhaps more Americans went to Paris because of the obvious philosophical connections between the United States and France — both were republics antagonistic to Britain — which did not pertain to Ontario. However, the attraction of the Paris hospitals was such that many English practitioners travelled to Paris for clinical training despite their distrust of the French and the need to learn a foreign language. Another possible explanation is that most practitioners with British qualifications in Ontario were emigrants, unlikely to have been up-and-coming practitioners who travelled to Paris to complete their education. This still does not explain why the elite Ontario practitioners who did return to Britain for their education did not include some time in Paris in their travels.

The one point held in common among Ontario, the United States, and Great Britain was the rising importance of medical appointments, especially in hospitals and universities. There was a myriad of such positions in Upper Canada by the 1860s: coroner, prison surgeon, and superintendent of the insane asylum, to name a few. The positions of status, however, were member of the Medical Board, staff member of a hospital, or medical lecturer.

In this period the fundamental difference between the United States and Ontario was the issue of professional identity. The American practitioner “derived his professional identity from practice”, stated the historian J. H. Warner. “There was little place in American society for a nonpracticing physician, the two terms were contradictory.”⁹² In contrast, the nonpractising physician was common in Ontario and was often involved in government. Perhaps the most prominent example was W. W. Baldwin, who never practised but called himself Doctor and received a large entry in William Canniff’s book.⁹³

The tone of the Canniff book illustrated these attitudes as well. The entries emphasized titled or important relations rather than discussing practice. In fact, this large book contains remarkably little information about the practice of the physicians it seeks to memorialize. Practitioners in Ontario drew their identity from their credentials (degrees and licences) and claims to gentility. There were numerous cases of practitioners complaining of other doctors, not because they were incompetent but because they lacked licences or were not the right sort of people. In 1834 James Sampson wrote twice to the Lieutenant Governor (once by special messenger because he feared his message would not arrive in time) to be sure that Dr. Barker, the

91 Dorothy M. Schullian, “Introduction of the Stethoscope and Clinical Auscultation in Canada”, *Journal of the History of Medicine and Allied Sciences*, vol. 22 (1967), pp. 414–417.

92 Warner, *The Therapeutic Perspective*, pp. 12, 14.

93 Canniff, *The Medical Profession*, pp. 227–237.

editor of "a paper called the 'British Whig' " not receive a licence because Barker was a "low radical" and "all the profession here would have much reason to regret that such a person such as he is, should have a place among them."⁹⁴ The 1853 rules of the Toronto General Hospital stated that, in order to be a resident medical officer, a practitioner was required to "lay before the Trustees, satisfactory testimonials of his moral character, and shall be a licensed practitioner of the province".⁹⁵ This appeal to credentials and gentility was similar to the British definition of professional identity rather than the American.

The factionalization within the medical profession was also reflected in general political cleavages.⁹⁶ In both Britain and the United States, the homeopaths and eclectics tended to be associated with radical politics. There is some evidence that in Ontario Thomsonianism was associated with a liberal or radical political outlook.⁹⁷ However, the conservatism of Ontario is demonstrated by the fact that, by the 1850s, the eclectics and homeopaths were agitating for equal status under the law, not a free medical market. At the most superficial level in Ontario the infighting within the regular profession reflected political and religious alliances. The different licensing solutions of the United States, Britain, and Ontario also illuminated their different political climates. The American decision to end regulation demonstrated that country's anti-authoritarian stance; Americans opposed monopoly, privilege, and chartered corporations using the rhetoric of democracy and their revolutionary tradition.⁹⁸ The British legislation was a triumph of *laissez-faire*, although it retained some regulatory powers and did not abolish the corporations as a sop to the Whig and Tory factions.⁹⁹ The Ontario decision to maintain regulation throughout this period demonstrated its social conservatism,¹⁰⁰ an attitude that was understandable: the citizens of Ontario felt that they lived in a British outpost, under threat of social disorder fomented in the nearby revolutionary democracy of the United States.

94 NAC, Medical Licenses, RG5 B9, v. 63, pp. 612–613, 619–620, 1834.

95 NAC, Provincial Correspondence, RG5, C1, v. 392, file 1299, 1853.

96 Ramsey, "The Politics of Professional Monopoly", pp. 248–249, discusses how one can map political differences onto disputes over medical licensing, using Britain as an example.

97 Jennifer J. Connor, "To Advocate, to Diffuse, and to Elevate", pp. 71–72, 106; see also Jennifer J. Connor and J. T. H. Connor, "Thomsonian Medical Literature and Reformist Discourse in Upper Canada", *Canadian Literature*, vol. 131 (1991), pp. 140–155.

98 Ramsey, "The Politics of Professional Monopoly", p. 252.

99 *Ibid.*, pp. 248–249.

100 Kett, in "American and Canadian Medical Institutions", also discussed the connection between conservatism and Ontario's medical institutions.