

## CHAPTER 1

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### Protestantism, Piety, and Professionalism

Whether trusted or not, doctors have used the Hippocratic oath for two thousand years as the equivalent of a social contract between the medical profession and the public, administered in modern times at graduation from medical school. Even though the legacy of that contract may now seem to raise more questions than it answers about the physician's duties, the original oath has been described as "the Medical Decalogue [equivalent to the Ten Commandments], universally accepted as such."<sup>1</sup>

That original, as translated by Ludwig Edelstein in his book *The Hippocratic Oath: Text, Translation, and Interpretation* (1943), reads as follows:

I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.<sup>2</sup>

A more contemporary adaptation was written in 1964 by Louis Lasagna (1923–2003), who was for many years the academic dean of Tufts University Medical School. As an introduction to the central concerns of this book, it is worth comparing the two.

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with

great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.<sup>3</sup>

Lasagna's updated pledge is a recasting to accommodate to more modern times: the Greek gods are no longer invoked, the language no longer refers to male family lineages or "pupils who have taken an oath" only, and the dismissal of "the knife" has been changed to acknowledge that surgery is often a key component of medical treatment.

Today, however, even relatively contemporary formulations like Lasagna's or an earlier one adopted in Geneva in 1948 by the Second General Assembly of the World Medical Association might seem dated. In fact, according to a recent graduate of Harvard Medical School, her class wrote its own, even newer pledge. Much has changed with regard to the moral and ethical challenges today's doctors face—and with regard to the implications of those challenges for the bond of trust between physician and patient. What has not changed is that within the profession of medicine the tradition of making a solemn commitment to adhere to certain standards of character and morality endures. And even in times that present them with many new dilemmas, fledgling doctors still vow to uphold those parts of the ancient oath that are seen as timeless. Respect for one's teachers; cooperation with one's colleagues; and above all, the protection of patients' interests, including a promise of confidentiality—these assurances are deeply embedded in the institutional foundations of what it means to be and act as a physician.

These foundations do not, for our purposes here, determine what a physician actually does; rather they represent a key to understanding the

historical belief in the United States that doctors are worthy of our trust. The Hippocratic oath was the first rhetorical foundation of that trust, the pagan halo under which all subsequent collective efforts to stipulate the physician's duties emerged.<sup>4</sup> And the sacred nature of that pledge, in all its contemporary variants and in the broadest sense of the word "sacred," still resonates in American society—despite an erosion of personal and public trust in doctors in recent decades—because of the historical connections between religious beliefs, religious establishments, and the medical profession.

### The Protestant Vision of Medicine as a Sacred Vocation

During the nineteenth century, formal codes of guidance for physicians in the United States were the direct inheritance of the work of three British physicians, John Gregory (1724–1773), Thomas Percival (1740–1804), and Michael Ryan (1800–1841).<sup>5</sup> In particular, Percival's *Medical Ethics, or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons* (1803) was the principal source for the "Boston Medical Police," a code of conduct promulgated by members of the Boston Medical Association in 1808. Medical societies in eleven other states adopted some version of this code in subsequent years, and on May 6, 1847, the American Medical Association approved the first national code of medical ethics at a gathering of physicians in Philadelphia.

Echoing the Hippocratic oath, these various codifications of expectations about medical conduct included specific directives about the duties of physicians to their patients (and vice versa), the obligations of physicians to one another, and the obligations of the profession to the public (and vice versa). The principle of reciprocity between physician and patient and between profession and public, as the late historian of medical ethics Chester Burns noted, was exemplified in the work of one American physician, Worthington Hooker, who published the only full-length study of medical ethics to be brought out in the nineteenth century. In writing about Hooker and his time, Burns concluded,

No American claimed that codes guaranteed medical righteousness. Codes simply provided physicians with some knowledge of the difference between right and wrong professional conduct. Without some ideals and some means of institutionalizing them, there would be little chance to alter professional evils anywhere.<sup>6</sup>

As the medical profession continued to evolve in this country, "righteousness" was indeed an issue, and the question of whether the meaning of this word relates to religion, to morality and character, or to strictly secular

standards of conduct is central to the broader question of trust. Historians of nineteenth-century medicine in the United States have long taken for granted its white, Protestant character, so much so that one key to understanding the nature of the public's almost universal trust in medicine, beginning in the middle of the nineteenth century and lasting until the middle of the twentieth, was the near uniformity of its practitioners not only in terms of their race, class, and gender, but also in terms of the kinds of cultural expectations that pertained to how they should act with respect to society, colleagues, and their patients.

In his book *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820–1885*, John Harley Warner writes,

In a commencement address to Cincinnati medical students in 1877 on “the dignity and sanctity of the medical profession,” the speaker asserted that “its chief excellence is not that it is scientific, but that it is redemptive.”<sup>7</sup>

To understand and explain illness were important parts of the physician's task, but they did not constitute the whole of it. The physician was more than a natural scientist; he was also a healer. Warner goes on to argue that the commencement speaker, Nathaniel West, was dissenting from the “still novel view that professional identity in medicine should be defined chiefly by science,” and in an article titled “Science, Healing and the Physician's Identity,” he interprets the “redemptive” dimension of medicine as being the humane impulse to act, whether or not the action taken had been scientifically proven to be therapeutically efficacious.<sup>8</sup> It is significant, however, that the speaker Warner chose to quote on this point was not a physician, although his talk was entitled “The Medical Science and Profession,” but rather a Presbyterian minister.<sup>9</sup>

The Reverend Nathaniel West Jr. (1824–1906) graduated from the University of Michigan and the Western Theological Seminary, and served in pulpits in Pittsburgh, Cincinnati, Brooklyn, and St. Paul.<sup>10</sup> In the clerical tradition of working through the relation of revealed truth to practical conduct, West followed the general practice of many other ministers who used the occasion of a commencement speech to put forth their own views about what was at stake in the fledgling physician's obligations to patients and profession.

Quoting Ovid, “Non est in Medico semper releveltur ut aeger” (The cure of the patient is not always in the physician's power), West remarked,

If any one, therefore, will seek the true occasion of the rise of the medical profession, he will find no sufficient explanation of this in science itself, but in an historic fact antecedent to all science, the

first violation of moral laws imposed upon man by his Creator. It involves questions which do not belong to medical science, as such, but to a totally different department of investigation—none the less important on this account, but all the more worthy of moral consideration, as throwing a peculiar sacredness around the profession itself.<sup>11</sup>

The “peculiar sacredness” West attributed to medicine was his way of acknowledging that, far from being hostile to science, the theological beliefs of enlightened Protestants encouraged an examination and justification of how the clerical and medical professions were engaged in a common pursuit of both physical and spiritual well-being.

West insisted that his remarks should not be interpreted as sanctioning all practices alleged to be medical. Charlatans were present in both the medical and clerical professions, he noted. He did not describe in any detail who, in his opinion, walked on the right side and who did not, but he did convey an overall view to his audience similar to that expressed several years earlier by Oliver Wendell Holmes Sr., who concluded in 1869 that although improvements had occurred in the relations between clergymen and physicians, “Whether the world at large will ever be cured of trusting to specifics as a substitute for observing the laws of health, and to mechanical or intellectual formulae as a substitute for character, may admit of question. Quackery and idolatry are all but immortal.”<sup>12</sup>

It seems clear that even while admonishing students about the limits and temptations of their vocation, West hoped to join the “scientific” with the “redemptive” in order to secure both a scientific basis for medicine and a theological guide for physicianhood. His long encomium to medicine was not nostalgic but rather intended to reinforce the idea that the new methods of scientific investigation were confirming of, rather than destructive to, Christian truths:

The skillful anatomist will cut away a whole hemisphere of the brain, slice by slice, and find the Apostle’s Creed or the Ten Commandments, faith in God and hope of immortality, with all the mental faculties, just as strong as before the chloroform and knife began their work. The living spirit is the same, its creed the same. Its ethereal essence survives the knife, the martyr’s flame, the tomb!<sup>13</sup>

In an age of rapid change and development, conflict among physicians about the therapeutic efficacy of differing approaches to disease and treatment did influence clergymen’s opinions of the medical profession.<sup>14</sup> But their central concern was contained in the advice they gave to physicians about their moral responsibilities, advice that was intended, at least in part,

to define new strategies for professing and promoting Christian faith and values in an era rapidly substituting scientific agnosticism for divine revelation. And in the end, modern codes of medical professionalism owe as much to this professing as to any advances in therapeutic technique.<sup>15</sup>

How ministers communicated the importance of specifically Protestant Christian piety in this context can be seen in a literature of preaching that was directed at medical students and, presumably, their teachers. Both Nathaniel West and Charles Quintard (whose pronouncements we will quote later) were among those ministers who used the occasion of a commencement ceremony to outline Christian ideals as they pertained to medical practice. It is difficult to reconstruct completely who was asked to deliver such addresses, and the vast majority of them, in any case, were not published.<sup>16</sup> But extant versions of speeches, sermons, and eulogies, a list of which is contained in appendix 1, provide ample illustrations of how Protestant clergymen approached the vocation of medicine during the greater part of the nineteenth century.<sup>17</sup> (Clergy asked to deliver commencement addresses to medical students during the second half of the century were overwhelmingly Protestant and male, although Lucretia Mott [1793–1880], the Quaker abolitionist and participant at Seneca Falls, made a speech to medical students in 1849 in Philadelphia,<sup>18</sup> and rabbis delivered several addresses that survive. Catholic priests, however, were virtually invisible in such quasi-public ceremonies.)<sup>19</sup>

Luckily enough for researchers, the preservation of some of the speeches and sermons delivered to medical students in one context or another was assured by an academic custom commonly employed throughout the nineteenth century. Graduating students would request in writing a copy of the graduation speaker's address for the purposes of publication and dissemination to a wider audience. The custom was routine in some places, for example, at the National Medical College or Medical Department of Columbian College, founded in 1822, which is today the George Washington University School of Medicine. At George Washington, only members of the medical faculty were called upon to deliver the address, and the same is generally true for older university medical schools established in the eighteenth century, such as Yale and the University of Pennsylvania.<sup>20</sup> In Philadelphia, a leading center for medical education throughout the nineteenth century, medical schools did not routinely invite clergy to speak to medical students at graduation, although they were regularly asked to open and close such occasions with prayer. But commencement speakers at newer, less tradition-bound institutions—like Tulane University, the University of Arkansas, the University of Maryland, Wayne State University, and the University of Michigan—included a variety of people other than physicians, such as clergymen, senators, governors, lawyers, writers, and university and college presidents.<sup>21</sup> In addition, a handful of surviving published talks by clergymen to medical students in other contexts

suggests that both groups often sought one another out in other ways.<sup>22</sup> (See appendix 2.)

A very instructive example, which I will focus on in some detail, is the sermon that the Reverend Henry Augustus Boardman (1808–1880), who led the Tenth Presbyterian Church of Philadelphia for more than forty years, delivered to invited medical students from the University of Pennsylvania and the Jefferson Medical College in 1844, at a special evening gathering at his church on Sunday, November 24. Two days later he received letters from representatives of each school, requesting that he make his sermon available for publication. In all, thirty-two students and faculty members signed the request, indicating that they were speaking for a larger audience in attendance that evening as well.<sup>23</sup>

Boardman began his sermon by quoting from the New Testament book of Colossians 4:14, which refers to “Luke, the beloved physician.” He was careful to observe that the term “physician” did not mean the same thing in Luke’s time as it did in his own. Striking a theme that would remain central to the Protestant clergy’s anxieties about their own duties regarding the well-being of their flocks, he concluded about medicine that “there is no science, theology excepted, which opens a nobler field of inquiry to the human intellect—none which is more intimately associated with our earthly happiness—none which is more entitled to the respect and veneration of society.”<sup>24</sup>

The training of physicians demanded “eminent qualifications, both of head and heart,” Boardman insisted, but one of these qualifications was “inculcated in the class-room only in an incidental way”—and that was the necessity of cultivating “personal religion.” The phrase “personal religion” was not meant to affirm a “bare intellectual assent to the truths of Christianity” nor “a rigid conformity to all the peculiarities of any particular denomination of Christians.” It was meant to be “synonymous with true piety,” consisting, “in general, in the renewing and sanctifying of the heart by the Holy Spirit, a cordial reliance upon the merits of Jesus Christ as the only ground of acceptance with God, and an habitual desire and aim to lead a holy life, and walk according to the pure morality of the Scriptures.”<sup>25</sup>

The ingredients of “true piety,” Boardman maintained, were available to all who were willing to subscribe to them, but he went on to outline seven reasons why physicians, in particular, might be vulnerable to both a lack of personal religion and to what he termed infidelity.

One concern of Boardman’s was that because of the demands of the profession, a physician might have insufficient time or motivation to examine the subject of religion, or to attend Sabbath worship. He also expressed concern that science itself might “inspire men with inflated views of the sufficiency of human reason on *all* subjects; and thus, from questioning the

necessity, they may easily come to deny the fact of a Divine revelation,” comparing “the habit of reasoning from induction and analogy which belongs to every scientific physician” with “the argument from miracles which constitutes so material a portion of the external evidences of Christianity.” He also concluded that physicians were more likely than others to see too much of the world of human suffering, and that this might erode their religious faith. “It may be worthy of consideration,” he stated, “whether familiarity with such spectacles has not sometimes assisted in fortifying them against the requisitions of Christianity, and even [hastened] them into infidelity.”<sup>26</sup>

The admonition that the scientific imagination could have a corrosive effect upon the moral character of the physician had to be carefully made to an audience of physicians in an era when science was subjecting traditional beliefs of all kinds to empirical inquiry. In this context, Boardman was careful not to attack science as such but only the indifference to spiritual needs that could arise from too great an absorption in the strictly medical. He then proceeded to examine specific attributes of character that were essential to the right conduct of the Christian physician, and the dangers to that character.

The first was that “physicians are exposed to peculiar *trials of temper*, as well from the unprofessional conduct of their brethren, as from the inconsiderateness, caprice and resentment of their patients.” Although personal religion “cannot secure them an exemption from these vexations . . . the temper fostered by religion—the meek, patient, forgiving, benevolent, ingenuous temper everywhere inculcated in the Bible, not simply as a graceful appendage of Christianity, but as one of its essential elements—is the best safeguard a physician can have against the wrongs we have been contemplating, and his best antidote to them when they *are* inflicted”:

A man with this temper will be uniformly just to his brethren and his patients. He will be slow to give, and equally slow to take, offense. He will be free from envy and suspicion, and will put the best construction upon all doubtful passages. He will be as jealous of his professional as of his popular, reputation. . . . Where he has perpetuated a wrong, he will not be ashamed, on discovering it, to acknowledge the offense, and make every reparation in his power. . . . All this, and much more than this, a physician will do, not because his interest will be promoted by it, nor simply because it is his duty to do it, but also because it is the very course to which his feelings prompt him, and which he finds his happiness in pursuing.<sup>27</sup>

In these characterizations of the ideal doctor, the qualities of action on the part of the physician were seen as not merely technical or formulaic; rather the Reverend Boardman described the discovery of personal happiness in

the intensification of professional obligations inspired by religious commitments. The fulfillment of duty for duty's sake was not sufficient:

The life of a fellow-being, and the earthly happiness of a family, may be suspended upon their decision of a question so nicely balanced that they [physicians] shrink from deciding it either way. The load of anxiety they sometimes feel in these circumstances must well nigh crush them to earth. The image of their patient follows them like their shadow; it puts them upon a reexamination of the authorities in their libraries; it throws a gloom over their fire-side enjoyments; it sits beside their couch at night; it makes them feel, for the time, that all the emolument and honors of the profession are no equivalent for its trials.<sup>28</sup>

To place squarely upon the physician all of the anxieties about the medical fate of the patient exaggerates the day-to-day reality in which most doctors, then and now, find themselves. The key to this aspect of Boardman's characterization turns on the degree of self-imposed pressure to redirect the "load of anxiety" into a constructive engagement with patients and their families, while at the same time his reference to "the emolument and honors of the profession" signals changes in the status of the profession within society.

### The Tension between the Vision of a Calling and the Rise of Professionalism

The professionalization of medicine in the United States during the second half of the nineteenth century has been the subject of numerous histories.<sup>29</sup> Scholarly efforts to describe the conditions of medical practice during this time have yielded a remarkable consensus about how scientific discoveries transformed the powers of physicians to heal. The improving economic fortunes of the profession have also been well documented and debated since the turn of the twentieth century.<sup>30</sup> Gradually, as scientific research was pursued in newly organized programs of undergraduate and professional education, the physician became the most popular symbol of professional authority.

At the dawn of this new era, the Reverend Charles T. Quintard (1824–1898), second Episcopal bishop of Tennessee, who practiced and taught as a physician before entering the ministry, had this to say about the tension between character and medical skill within the profession itself:

I have thus glanced at some of the moral characteristics of the true Physician, and have alluded, incidentally, to his mental qualifications.

These last, however, are sometimes, and I may say often found disconnected from the former. Brilliancy of intellect and profundity of learning, do not pre-suppose either benevolence of disposition, or purity of heart. . . . Good men are not all physicians, nor are all physicians good men. I may esteem and honor a man for his purity, but I cannot esteem a physician who trusts alone to kindness of disposition for the performance of his duties and responsibilities.<sup>31</sup>

Quintard, like many other ministers, was not indifferent to the powerful claims of an emerging scientific medicine. He was especially aware of the new as well as the enduring meanings of physicianhood. At this point, it is worth noting, the basis of the profession's increasing cultural authority derived from the proximity of the established, but declining, public influence of the clergyman alongside the growing public visibility of the doctor.

An illustration of the latter can be found in the self-congratulatory depiction of the final dinner of the sixth annual meeting of the American Medical Association in 1853 in New York City. "No assemblage in America," wrote a correspondent to the *Ohio Medical and Surgical Journal*, "perhaps in the world, ever met combining so much moral worth, self-denial in the cause of humanity, disinterested exertion for the advancement of science and a more thorough identity of educated alliance to our free institutions than this did." Toasts offered at the occasion included "Divinity, Law, Medicine—Three graces, all of which combined, support each other." Responding to this toast, the Reverend Samuel Osgood remarked that divinity and medicine were "interpreters of the same heavenly mercy," and he "gave the following sentiment, after speaking of medicine as nature evangelized":

Medicine and Divinity—The two stood together in the beginning, when science was darkened by superstition; they shall stand nearer together at the end, when science and faith shall be recognized as different, but harmonious, aspects of the same divine wisdom and goodness.<sup>32</sup>

The ritual comparison of each of the learned professions (law, divinity, and medicine) to one another was often made on formal occasions that celebrated professional authority, and the Reverend Osgood's remarks would appear to secure the pious end of that comparative spectrum. But such comparisons were also the source of revealing humor, if not impiety. Delivering the valedictory address to the University of the State of New York Medical Department in 1860, Dr. Seth L. Chase observed,

The physician's duties [are] more arduous than those of other professions. The clergyman prescribes once a week to his patients *en masse*, each one of them selecting the medicine best adapted to his

neighbor's case. (Laughter.) The lawyer can with impunity allow the scales of justice to continue vibrating for an indefinite time. On the contrary, the physician must go when and where he is called, leaving the quiet fireside, the interesting book, pleasing society, his bed, everything, to answer the call for aid against the destroyer.<sup>33</sup>

Compare Dr. Chase's observations to those of Dr. Troyen A. Brennan in 1991:

To allay his [a patient's] fears, Dr. A. drove over to the hospital, excusing herself from a dinner party. . . . This kind of visit is one of the most gratifying aspects of medical practice. But it is not really part of relations between citizens in the liberal state. Dr. A. could have called the house officer physicians and ensured that the blood counts were to be checked. That would have been adequate. Yet it would not have fulfilled the sense of duty and affection Dr. A. and other doctors have for their patients. . . . While I would hardly call a simple visit like this one a virtuous or altruistic act, it does represent a morality in which more than a simple "contract" between two autonomous people is expected.<sup>34</sup>

The contrasting assumptions that underlie these two quotes captures the very different expectations about the calling or vocation of medicine in 1860 as compared to 1991, and in so doing raise the question about how the expectations about doctors' duties in 1860 became the cultural expectations of both patients and physicians for more than a century. A second question is how the "sense of duty and affection" relates today to what is "adequate," and what both have to do with trusting doctors.

Meanwhile, returning again to the nineteenth century, no well-educated Protestant minister in the United States could ignore the public consequences of the physician's emerging powers. The gradual disestablishment of Protestant authority in America led those in religious offices to accommodate themselves to new leadership in the medical community that sought to organize and direct an overtly professional system of higher education.<sup>35</sup> Daniel Coit Gilman (1831–1908), first president of Johns Hopkins University, had considered the ministry but resisted because he sought, finally, to impose a duty on society rather than on individuals. Contemplating a vocation in 1854, at the age of twenty-two, Gilman wrote:

I told him [Noah Porter, who later became president of Yale University] that if I should become a minister I should want to preach about every day affairs—not in the style of H.W.B. [Henry Ward Beecher] if I could get above it, but in a more dignified manner—and that instead of dwelling long and regularly upon such points as

original sin and the doctrine of election, I should urge the practical application of the Bible to common events and daily habits.<sup>36</sup>

Gilman recognized early on that the future of medical education required organizational changes that no church-affiliated leader or church movement could be relied upon to help effect, and within decades Johns Hopkins University Medical School had become the exemplar of contemporary medical education and research as the new discoveries of science enhanced its prestige in ways that religious elites could no longer emulate in the older, more established schools, all of which rapidly followed the lead set by Hopkins during the first quarter of the twentieth century.<sup>37</sup>

In an important defense of the professional order fostered by elite physicians during the second half of the nineteenth century, Barbara Gutmann Rosenkrantz dismisses as “a post-Flexnerian myth” the argument that professional authority was achieved exclusively by “wringing out the medical economy through reducing the number of poorly trained doctors.”<sup>38</sup> The old ethics, she contends, embodied in the AMA’s code until its substantial revision in 1903, were neither antiscientific nor antiprofessional; rather they were rooted in specific qualities of professional tolerance that were being transformed by the demands of a new professional order that included considerations of “standing in medical school, hospital staff membership, and participation in specialists’ societies,” and which replaced “the outworn armatures of latitudinarian collegiality.”<sup>39</sup>

Rosenkrantz has described the prebureaucratic features of medicine as its practitioners began their adaptation to the new rules of scientific meritocracy at the end of the nineteenth century. Who, in fact, was qualified to enter medical school, to practice, and to consult, were all questions that new forms of accountability would settle, at least in principle. But at the time, for the elder statesmen of the profession, “a professional ethos in which accountability to science replaced relations with colleagues and patients was a crack in the wall of tradition that had supported the reputation and authority of medicine in the past.” Trust in physicians was still affirmed first in their social relations with peers and patients. Rosenkrantz sees the emergence of a new professional identity as not simply “a transformation of vocation authorized by the growth of scientific knowledge,” but also as the transformation of the “reputation and authority of medicine.”<sup>40</sup>

The idea of a “transformation of vocation” requires further elaboration, insofar as the collegial culture of physicians—a key element of the legacy of the Hippocratic oath—is viewed from their standpoint alone. As important as the medical profession’s internal disputes about new theories and treatments may have been to physicians themselves, notice was also taken by others. Humorous aphorisms, composed by outsiders to medicine over

millennia, were again quoted to confirm the fact that little real progress had occurred in the physician's understanding of disease and its treatment—a point that harkened back to an earlier vein of popular distrust of physicians. As the transformation of vocation under the new dispensations of science proceeded, the threatened ethos of physicianhood as defined in part by gentlemanly and collegial authority was rescued once again with the ever persistent tradition of personal authority whose origins we can trace in this country to the endorsement and beliefs of Protestant ministers.<sup>41</sup>

In this context, I would argue that what remains of the moral authority of the doctor today resides in what is abstractly called the “physician-patient interaction.” In his sermon of 1844, Boardman referred to the Puritan divine Richard Baxter, who “remarked [that] what belongs to the pastor *ex officio*, belongs to the physician *ex charitate*.” Unlike the pastor, the physician “has access to individuals whom no clergyman can reach,” and

the same counsels uttered by him would be more likely to produce a good impression than if they came from the lips of a clergyman, because, in the latter case, they might be heard as the promptings of professional duty, while in the other, not only would they be ascribed to a generous and disinterestedness kindness, but they would derive additional weight from the presumption, on the part of the patient, that they proceeded from one who understood his physical condition.

Boardman concluded that the physician “has an ascendancy” over the patient “which no other person can have—that his imagination (to borrow the expressive language of a learned and venerable professor in one of our medical schools) has ‘conferred on him the attributes of a *tutelary divinity*.’”<sup>42</sup>

Acting in the capacity of a “tutelary divinity” was, in Boardman's view, the physician's most important role: “There can be no doubt,” he stated, “that the sick sometimes suffer intensely from *suppressed anxiety* in relation to their spiritual state. . . . A few kind words of spiritual counsel, kindly offered, have, in some instances of this sort, done much to tranquilize the system, where the best pharmaceutical agents have failed.” Here, early on, we can sense the tension between the commitment of doctors to religiously based moral precepts and the emergence of new ways of evaluating their conduct. Boardman acknowledged that “different cases require different treatment,” but maintained that “the responsibility of physicians is not restricted to their merely technical duties.”<sup>43</sup>

The practice of inviting medical students into Philadelphia churches continued with a sermon preached by Joel Parker (1799–1873) in the Clinton Street Presbyterian Church in 1848. The Reverend Parker spent most of his

career in New York City and was an early president of Union Theological Seminary. Parker began his sermon by quoting Luke 4:23, "Physician, heal thyself," noting that this was one of several places where Christ compared "the functions of the spiritual teacher to those of the healing art." Parker's comparisons were clearly sociological: "Neither Clergyman nor the Physician, have anything to do directly with the estates, the social position, or the political relations of their fellow citizens."<sup>44</sup> The pastor's and the physician's influence alike were directed toward persons as individuals; thus, the pastor or the doctor "cannot exercise the influence of a good man without *being* a good man. He cannot banish bad moral influences, without being himself personally averse to them."<sup>45</sup> But Parker also cited a symptom of the changing balance in terms of public regard for ministers and doctors, one that points to the tension between the professions, when he observed:

It is not uncommon for Physicians to resist the visits of clergyman till the last hope from medical remedies is extinct. That there are cases which demand such a procedure, no thoughtful person can doubt. But when it is made a rule to pursue this course, it creates an impression in the community of such a character, that the moment the clergyman is sent for, the sustaining influence of hope is suddenly taken away, and you might as well sound his funeral knell in the ear of the patient, as to propose a visit from the minister of the gospel.

Parker also commented that "corrupted forms of Christianity [thus referring to Roman Catholicism] . . . pronounce incantations over the dying, and anoint the extremities with oil, and exorcise evil spirits by shreds of unclassical Latin."<sup>46</sup> His view of the physician's responsibilities required that the doctor maintain a more than strictly medical relationship with the patient, but also that the clergyman be available to assist at other times than during the final hours of life. The Catholic approach did not preclude such a relationship between a doctor, his patient, and a member of the clergy, but Parker and other Protestants saw "spiritual counsel" as distinct from and superior to ritual practices.

Despite the scorn expressed by Parker about "corrupted forms of Christianity," he acknowledged that Protestant ministers were also sometimes a source of anxiety from the perspective of doctors and patients. Physicians "are afraid that he [the clergyman] will present religion in its gloomy aspects and agitate the patient with oppressive fears or fill his mind with hot and injurious excitement," he noted, and he expressed the hope that doctors would not ignore the useful function of the clergy because the zeal of a few might disturb their patients.<sup>47</sup>

The clergyman's interventions were complicated by this issue, but the physician's interventions, particularly on matters of personal conduct, required careful guidance as well:

Men will apply to you to heal diseases occasioned by intemperance, or other vicious indulgences. A sound ethical code undoubtedly requires it of you, not to injure the reputation of those who entrust you with a knowledge of their faults. When you know their secret sins, however, and when you are careful not to use that knowledge to their disadvantage, you have the finest opportunity to employ the power of reproof successfully. You can prescribe virtue as a remedy.<sup>48</sup>

The idea of "virtue as a remedy" falls squarely between a religious hope and a medical responsibility, especially in those matters pertaining to the conduct of a patient that might have adverse effects on health. The responsibility to reprove a patient about failure with regard to the virtue of temperance, for example, was something a physician could consider valid both religiously and medically. The key to understanding the specifically Protestant dispensation on how a physician was to think about this responsibility is contained in the word "prescribe."

What seems clear in retrospect, after more than a hundred years of the institutional displacement of religious authority in the United States, is the inevitability with which physicians, in particular, were regarded as the successors to ministers in matters of individual moral guidance, at least insofar as the behaviors so guided had medical implications. Not every physician viewed this part of the medical practitioner's role in specifically Christian terms, but even as its influence waned, the Protestant establishment's insistence that the physician must first be a believing Christian, and thus a righteous person, gave added public credibility to the rising status of the physician's office, that is, his position of authority in society.

In other words, in Parker's system of values, the personal *was* the official, and his caricature of Catholic ritual was a rebuttal to anyone who argued that person and office could be separated. Martin Luther had noted that any office might inspire respect even if those who held it were not pious, but Parker's view of society insists that the inspiration of public confidence in any such offices or authorities rests on the spiritual condition of those who occupy them. Returning to this theme again and again, he concluded,

You cannot win for yourself the esteem, the heart-felt confidence that is cheerfully awarded, by almost every one to a pious physician, without being a good man; without fearing God and keeping his commandments. You may think you are doing it by substituting

a spiritual finesse for piety. . . . Yet, if you be not a true Christian, men will penetrate your sinister management.<sup>49</sup>

“Physician, heal thyself” thus became, in Parker’s vision, an opportunity to offer a renewal of confidence in the office of the medical doctor against the ever-lurking prospects of “sinister management” that might develop if the physician lost sight of the sick-chamber as a sanctuary:

We turn again to the solemn scene, and listen to the sobs of the widow and the orphan, and there stands the physician, a cold skeptic, or an indifferent man of the world. How shall he administer spiritual comfort? He cannot do it. He is himself bereaved. In his patient, he has lost a friend. He has need to heal himself.<sup>50</sup>

Parker knew that he was instructing by analogy. “Gentleman,” he told the medical students in his audience, “you may think that I am endeavoring to impose upon you responsibilities which belong only to my own profession. . . . Our duties arise from our relations and our opportunities for doing good.”<sup>51</sup> This slightly ambivalent attempt to encourage unity of purpose by appealing to the complementarity of roles of religion and medicine was also evident in many other clerical addresses on the physician’s moral authority. (A brief aside: The origins of today’s new arenas of specialization in the administration of what nineteenth-century Protestant ministers spoke of as “spiritual comfort” may be attributed to the public’s wide exposure to diverse religious ideas and psychological theories in more recent decades. And later attempts—by social scientists, for example—to disestablish further the special status of physicians must first be understood in light of this historical background of the efforts of Protestant ministers to transfer something of their own authority to their professional peers in medicine.)<sup>52</sup>

In the same year that Joel Parker delivered his sermon, the Reverend Joseph Frederick Berg (1812–1871) of the Reformed Church, spoke to medical students from another school, Pennsylvania College, in much the same vein. Berg emphasized especially the healing powers of Jesus: “He gives but one prescription, and that is *faith*. All who trust him are healed.”<sup>53</sup> And he did not shy away from insisting “that whatever may be said respecting the propriety of the Christian minister’s being qualified to practice the healing art, there can be no doubt that every physician should be fully prepared to preach the gospel.”<sup>54</sup> “The physician cannot work miracles, neither can we,” he stated, and then he asked, “But can we not console them?” The Protestant vernacular, which was used in discussing how divine revelation related to everyday matters, touched often upon the matter of consolation, carefully avoiding any special claim by the minister to provide such, but insisting that the physician, like the minister, should recognize the necessity and the

challenges of doing so: “And that may be in our profession as decidedly malpractice as it is in yours, to administer a sedative when the system needs a most powerful stimulant.”<sup>55</sup>

Another important element of the Protestant contribution to the enduring values first espoused by the medical profession in the nineteenth century is exemplified in the sermons of Elias Root Beadle (1812–1879), pastor of the Second Presbyterian Church in Philadelphia, who preached twice to medical students from Jefferson Medical College and the University of Pennsylvania, in 1865 and 1874. Although Beadle drew many of the same conclusions about faith, moral character, and the vocation of medicine that his fellow Philadelphia clergymen had endorsed, he was more direct about the hierarchy of callings:

I greet you here, and hail you only to give you words of cheer. I respect your choice. I disparage no other profession. My presence here to-night, is evidence that there is one which I prefer before it. I wish you had done the same; but I leave that with God and you. I honor all professions and all lawful callings.<sup>56</sup>

And, while still using the vocabulary of faith, he put a new kind of moral pressure upon the emerging profession, insisting, for example, that doctors minister to the poor: “Though they cannot recompense thee; but, *‘thou shalt be recompensed at the resurrection of the just.’*”<sup>57</sup>

Beadle spoke about the physician’s obligation to what would later be termed public health in both his sermons. In 1865 he observed,

And the question is fairly pressed upon you at this moment, whether you cannot arrest the physical degeneracy, so apparent in our time, and restore human life to its normal conditions. Whether by insisting upon a better mode of life, more nutritious food, purer social enjoyments, higher mental culture; by retarding the speed and lessening the pressure of all commercial and business life, you may not again enlarge its boundary and change the whole face of human society.<sup>58</sup>

By 1874, as the United States became more and more industrialized and both migration to the cities and immigration increased, Beadle’s perception of the effects of urban crowding on public health had become more sophisticated and more specific:

As population has largely increased, and necessities of civilization compelled men to herd in cities, to crowd manufactories, to gather in large armies, to live in unhealthy localities [*sic*] and labor under influences adverse to health, many questions will arise which the

wise and thoughtful physician can alone properly deal with and answer. Clear and decisive sanitary knowledge must be reached and disseminated. Causes which impair public health and shorten human life must be sought out and removed. City life, prison life, different forms of labor and all forms of exposure, must be studied and the essential conditions of health, ascertained and made known. . . . The command to “Heal the Sick” [Matt. 10:8] covers much ground. It is both to work cure and remove cause.<sup>59</sup>

Combining a deeply religious and thus conservative view of the ideal character of the doctor with a progressive outlook about the most significant health problems of his time, Beadle balanced an evangelical approach to public health with the classic mission of saving souls.

In no other hands are such sacred trusts deposited as in yours. You are the confidant of families. You carry the strange and often sad secret of human hearts. You are admitted to privacies which are denied to all others. . . . It is here, in the very citadel of all sacred relations and social excellence that your integrity will be tried and your character as men and physicians put to the severest test.<sup>60</sup>

By admonishing his listeners about the “sacred” character of the “strange and often sad secret of human hearts,” Beadle was also endorsing the authority of physicians to minister in special ways when clergy could not.

In the end, what resonates above all in the speeches given by Protestant clergymen to physicians throughout the nineteenth century is the deeply held conviction that the vocation of medicine added up to more than the sum of training and ability. Preaching to the medical students of Jefferson Medical College in 1863, the Reverend Stephen Townsend, M.D., concluded,

To follow a calling involving such duties and responsibilities, something more than an intimate acquaintance with anatomy, physiology, chemistry, therapeutics and the principles and practice of medicine, surgery and obstetrics is required. You must be filled with an exalted sense of the onerous duty, the moral and religious obligations, and the profound responsibility which are inseparably connected with your mission; and you must come to the work, moreover, with an earnest, sincere and truthful desire to advance the interests of medicine, and thereby the prosperity of men, as far as in you lies the power.<sup>61</sup>

It is this now seemingly ineffable and indefinable “something more” that shines, like a halo, above those callings in which success demands both personal presence and personal understanding, in a word, trust.