
One hundred years of an association of physicians

M. WEST

Cardiff School of History and Archaeology, Humanities Building, Cardiff University

Summary

The creation of this Association stands out as one of the most important landmarks in the history of British medicine. To appreciate its importance and significance we have to remember the state of affairs previous to its conception. The great hospitals and medical schools scattered throughout the country lived largely isolated existences. Even in

the large cities there was a minimum of contact between the staff of one hospital and another. An isolation which is now hard to appreciate. Even in the metropolis, the great teaching hospitals tended to live unto themselves, a kind of glorified independence... The Association changed all that.¹

The Association of Physicians of Great Britain and Ireland was founded in 1907 by a group of London-based consultant physicians, many of whom held teaching hospital posts. The Association aimed to bring together physicians from across Britain and Ireland to encourage friendship and the promotion of internal medicine, which at the time was defined as the knowledge of illnesses and medical processes within the body.² The timing and aspirations of the foundation of the Association raise numerous questions about contemporary perceptions of the status of medicine in Britain and the professional concerns of physicians at the start of the twentieth century. Even more important, however, are the issues that the last one hundred years of the Association raises about nature of medical societies and their role in the formation of professional identity, the importance of personal networks to the professional and intellectual development of medicine, especially in the early years of its history, and the nature of twentieth century medicine.

The Association was established at a time of uncertainty for many British physicians. On the world stage, contemporaries feared that Britain was losing her imperial standing and economic dominance.³ Many physicians also felt that medicine in Britain was falling behind at an international level. A perceived lack of unity among physicians, and debates about the value and role of modern, laboratory science in medical training and practice, added to this anxiety.⁴ The creation of the Association was in many ways a response to the

changing situation the founding members were experiencing. It provided a means to assert their authority and identity in the rapidly changing world of twentieth-century medicine. To understand the history of the Association, it is therefore first necessary to place it in context to examine how and why it developed.

The “right kind of way”: medicine in Britain

Intense professional debate about the nature and structure of medical education came to the fore from the 1870s and 1880s onwards. If doctors recognized that science and experimentation had always played an important role in medicine, it was the type of science first through experimental physiology and then through the laboratory sciences that created problems. Arguments about the best way of educating future medical practitioners centred on the relative merits of the bedside, the clinic, the post-mortem room, and the laboratory. As the historian Susan Lawrence has explained, during the late nineteenth century ‘controversies raged around reforming the medical curriculum to include the “right kind of science” in the “right kind of way”’.⁵ Some contemporary clinicians argued that training in clinical pathology was most appropriate; others believed that the laboratory sciences offered rapid medical advancement and the best way to understand and diagnose disease.⁶ Universities, such as

Cambridge, strongly supported the advancement of clinical pathology; hospital medical schools, especially those in London, were more committed to traditional methods of bedside training.⁷ In reality, the situation was more complex than this simple juxtaposition of the role of 'science' and the relative value of traditional, bedside learning. The word 'science' and its position in medicine covered a wide range of complex meanings and values. Those who believed that 'laboratory medicine' was vital to progress were hampered in their attempts to introduce it into the medical curriculum, because there was no clear definition of what constituted science.

These debates about how future doctors should be trained reflected growing, well-founded anxieties about Britain's international status—both on the world stage and in medicine. Throughout the last decades of the nineteenth century, other countries began to threaten British imperial hegemony. By the 1880s, decline in Britain's industrial strength was visible, and by the 1890s, it was surpassed by the USA and Germany in the crucial production of steel.⁸

Physicians also voiced fears about Britain being left behind. For physicians, there was a striking contrast between Britain and Germany. After 1850, Germany started to lead research into the basic sciences of microanatomy, physiology and organic chemistry through the development of university and research laboratories. The United States was also forging ahead in the field of academic medicine. By the beginning of the twentieth century, American universities and medical schools, notably Johns Hopkins, were seen to be leaving British medicine behind.⁹ Unlike Germany or the United States, Britain had no tradition of clinical experimental work or academic medicine at a university level. There was little money available for medical research. Academic departments of medicine, where doctors could pursue research 'untrammelled by the necessity of earning their daily bread', did not exist.¹⁰ The investigation into medical science in Britain by Abraham Flexner, author of *Medical Education in the United States and Canada*, explained that:

Clinical teaching in London remains an incident in the life of a busy consultant... no certain reward stimulates the young physician to engage in original work. His cue is faithful routine. In consequence his preliminary scientific training goes largely to waste.¹¹

In addition to the concerns that these developments caused, divisions in British medicine heightened

anxiety. The early nineteenth century had seen moves to medical reform and although some success was achieved through the 1858 Medical Act, which established a system of state registration for 'orthodox', qualified doctors, the professional landscape remained complex and creation of a unified medical profession was slow to emerge.¹² Divisions existed at all levels: between metropolitan and provincial practitioners, between generalists and specialists, between consultants and general practitioners. Nor was there much evidence of physicians from different institutions working together. As the historian Roy Porter has emphasized, the London medical schools were isolated establishments, only loosely governed by the General Medical Council (GMC). Individual consultants concentrated on their own areas of research and there was no collective encouragement for their investigations.¹³ The division between physicians in and outside London exacerbated the feelings that medical research in Britain was falling behind that of other countries.¹⁴

The Association of Physicians, therefore, was founded amid a context of division and anxiety in the medical profession at a time when it was becoming increasingly evident that British medicine was falling behind that of Germany and the United States, reflecting wider anxieties about Britain's imperial standing. Most hospital physicians worked in relative isolation. Conflicting ideas about the contents of the medical curriculum and the future of medical research separated an already segregated profession. It is only by understanding this context that the significance of the aims and objectives of the Association becomes clear.

Medical societies

However, the foundation of an Association was not a radical departure from earlier organizations. Throughout the nineteenth century, medical practitioners were striving to professionalize and assert their status and authority. They were sensitive to their social position and felt the need to increase their unity and status. The creation of medical societies was an expression of these anxieties, and a way of fostering the identity of medicine as a 'profession'.¹⁵ They were part of a wider network of associational activity and civil society that historians have argued provided marginal groups with a means to promote cohesion or shared values. At the same time, these societies offered a mechanism through which these groups could affirm their growing independence and identity.¹⁶

During the nineteenth century, the proliferation of medical societies in Britain reached new heights, as

did other forms of associational activity. Many were initially established in the early nineteenth century to promote medical reform and came to provide a means for practitioners to work together and share ideas. They offered opportunities for the discussion of professional as well as scientific matters. As a result, they had a substantial impact on the development of the medicine as a profession, especially outside London where local medical societies flourished. For Inkster, this was because many medical practitioners were 'marginal' or culturally isolated. Not only were they members of a profession that was still developing, but they were also striving for status in the areas in which they practiced.¹⁷ Although the increase in the number of qualified medical practitioners and growing competition in medicine did mean that most towns and cities often had more than one practitioner, many remained professionally isolated. This sense of professional isolation was not limited to provincial practitioners: doctors in London could also be professionally isolated, while individual feuds and competition led to the emergence of cliques. However, it was in the provinces that the need to improve communication and professional status was felt most acutely.

The formation of local medical societies therefore reflects a growing self-awareness among doctors of their position and the need for unity, cooperation and the development of professional objectives. Medical societies provided an arena through which cohesion among practitioners could be fostered, allowing them to work together to develop and promote a professional identity. In the same way, the foundation of the Association demonstrates on a grander scale a growing awareness among physicians, especially those in London, of the need to bridge the gap between those working outside the capital and those in London. In order to maintain standards, and for medicine and the nation's health to progress, it was recognized that shared values and knowledge were needed.

The threat from specialization

Another strand in the origins of the Association was the concern felt by many generalists about the impact of increasingly specialization on medicine. Although specialists had existed before 1850 and had often been dismissed as empirics or quacks, in the nineteenth century specialization took on a new momentum. The process of specialization was encouraged by a number of factors, including changes within medicine, demand for specialist care, and the development of new instruments such as the ophthalmoscope or the laryngoscope, which

encourage particular fields to develop. Professional concerns also played an important part in specialization. Becoming a specialist represented one way of going up in the medical world, of circumventing the nepotism and barriers that existed in many large metropolitan hospitals. Specialization allowed outsiders to rise.

The majority of generalists resisted specialization. Opposition came from two sources: economic and intellectual. In Britain, general practitioners, fearing for their incomes, felt that specialist hospitals stole patients away from them. Those working in teaching hospitals were equally antagonistic. They believed that specialist hospitals drew interesting cases away from them, hence damaging training. At an intellectual level, opposition to specialists reflected a battle between different views of medicine. The main body of status-conscious doctors came to believe that medicine was essentially holistic—that to understand disease you had to understand the whole body or patient. Specialization was characterized as narrow-mindedness, encouraging doctors to diagnose their favourite condition in every patient they saw when they should be looking at the whole patient. This was perceived to be dangerous in a climate where it was commonly believed that all diseases were connected, and that a knowledge of one was necessary to understanding another. It was argued that specialists put the patient at risk because they only knew about a specific disease. Specialization was a threat to how many doctors viewed medicine.

Specialists were hence forced to defend their position and assert their own identity within the fast moving and competitive medical market. They did this through the creation of specialist hospitals and medical societies, which helped them carve out a position and an identity. By 1908, there were approximately 177 medical societies in England. Of this number, there were seventeen specialist medical societies in London alone. This figure does not include the sections of the Royal Society of Medicine which in 1907 incorporated, by Royal Charter, fifteen specialist medical sections 'for the cultivation and promotion of medicine and the branches of science connected therewith and allied thereto'.¹⁸

The development of specialist societies is significant when considering the foundation of the Association of Physicians. In 1907, the conflict between specialists and generalists was acute. The Association's foundation was an attempt not only to unify elite physicians, who often worked in the relative isolation of their own hospital, but also to bring together physicians in order to maintain an essentially metropolitan and generalist concept of medicine. In the same way that specialist societies

brought together specialist physicians to promote their area of interest and to establish themselves as a professional group, so too was the Association started as a way of defending the importance of the generalist in medicine. This did not mean that those who initially supported the Association were reactionary. Although as the historian Christopher Lawrence has argued, supporters of 'holism' (in this case used to mean the defence of generalist medicine against reductionist views that a medical problem could be understood by reference to one or more fundamental constituents) were more obvious among conservatives and critics of change, support for generalist medicine was more widespread.¹⁹ The Association hence offered a way of protecting its members from becoming lost in a new, increasingly heterodox medicine, and provided a means to establish them as men with authority who should be respected for their distinguished contributions to medicine.

Beginnings

The first meeting of the Association of Physicians, held on the 23rd and 24th May 1907, was the product of an important period in British medicine and marked the beginning of its own role in the promotion of the application of science to medical practice. The foundation of the Association challenges the idea that elite physicians were opposed to laboratory science. First, they aimed to pursue a greater knowledge of science in relation to medicine, which would enhance the understanding of internal medicine. Second, the founder members of the Association intended to promote greater unification among self-identified elite physicians with similar professional interests.²⁰

Quarterly journal of medicine

The idea for an 'association' of physicians came out of an earlier suggestion for a journal of scientific papers. A number of prominent physicians had discussed the idea for a journal. One of these men was William Hale-White, a founding member of the Association and physician to Guy's Hospital. He recorded the event in his own words:

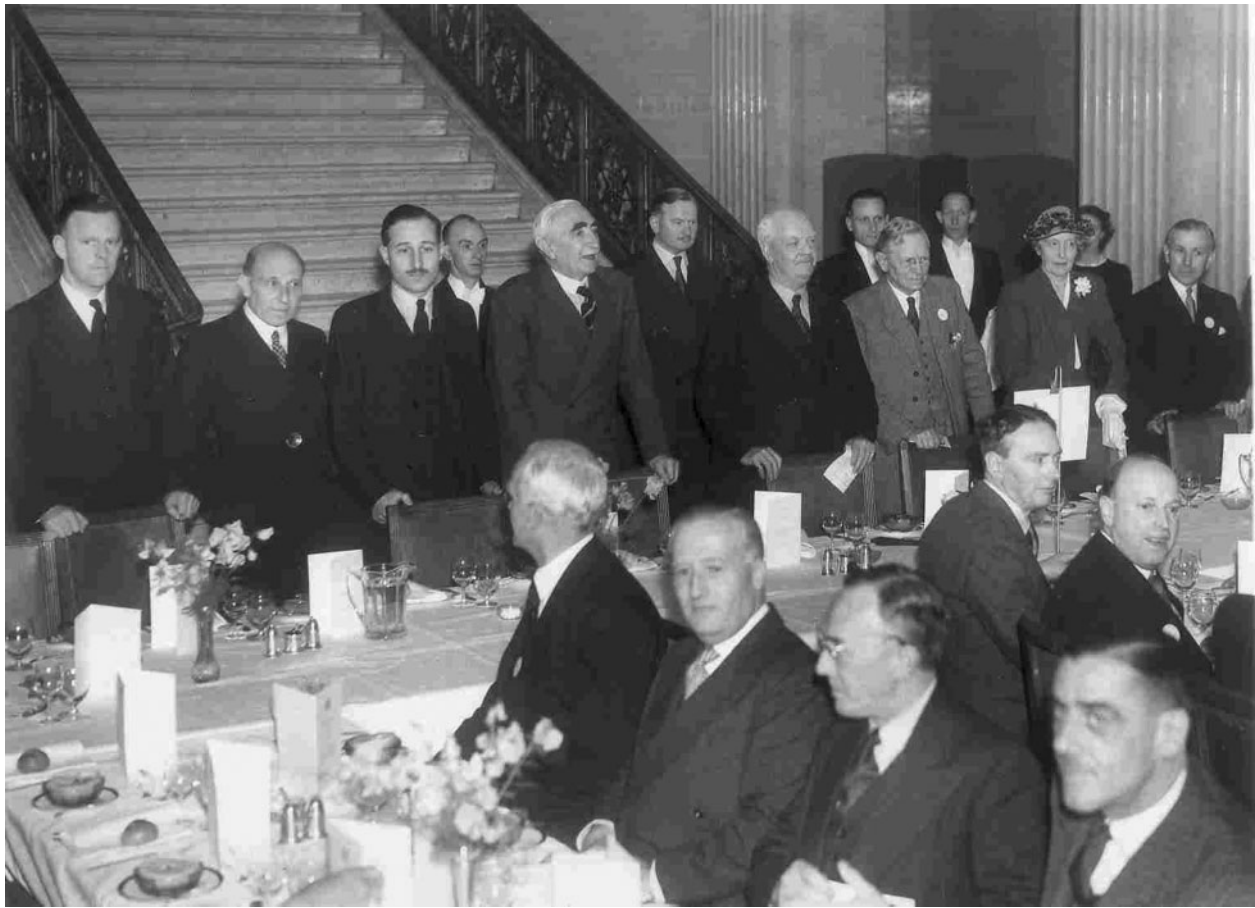
Many years ago, Kanthack, Garrod, and I considered the publication of papers, which, although of interest to those working at the scientific aspect of medicine, did not appeal to the majority of those in practice.²¹

The original name given to the journal was the *Archives of Medicine* and although this was changed before the publication of the first issue in 1907, the original title gives some indication of the intentions for the journal.²² It demonstrates a desire to pursue the achievements of medicine on an international scale. A journal of this title would have reminded readers of a comparable German journal of the same title which had been established by cellular pathologist Rudolf Virchow. The stated objective of the founding members was to create a British journal that would promote scientific knowledge among physicians who were engaged in similar areas of research, or who had an interest in the work of others in their field. It sought to document the changing nature of medical research. However, unlike other existing journals, such as the *Lancet* or the *British Medical Journal (BMJ)*, the new journal was not aimed at the profession as a whole but at consultants working in teaching hospitals. The quality of science was of the utmost importance to the founders. Wilmot Parker Herringham, one of the leading figures in the creation of the Association and a Physician at Barts, gives an indication of the mood behind the proposed journal. In a letter outlining the beginnings of the Association he explained how:

A wish had often been expressed that some magazine could be started in this country, on the lines of one or two of the foreign magazines, in which papers, which, though scientifically important, were not suitable for the journals, nor for the Clinical or Pathological Society, could be published.²³

These intentions demonstrate an enthusiasm among generalists for a greater knowledge and dissemination of modern, scientific medicine. In this way, the founders hoped that the new journal would not only unify physicians working in the old general and metropolitan hospitals, but also help foster an identity in the face of the increase of more 'scientific' specialist hospitals and medical societies, particularly those outside London.

However, the original scheme was delayed by the death of Alfredo Antunes Kanthack, deputy Professor of Pathology at Cambridge and the pathologist at Barts.²⁴ His importance to medicine in general, and therefore to the proposed journal, was clear. A prominent figure in the development of clinical pathology and bacteriology and a respected consultant physician, he proved that pathology had a role to play on the wards and developed bacteriological diagnosis as an adjunct to clinical methods. He considered it his life's mission



43rd Annual Dinner, Belfast, Courtesy of the Royal College of Physicians, 3 June 1949, 2434/71.

to devote all his energy to developing the scientific spirit in medicine. His death therefore set back efforts to create a new journal. It was only after Sir William Osler became Regius Professor of Medicine at Oxford University in 1905 that the idea for a journal was revived.

Osler's vision

William Osler (1849–1919) had a passion for the professional development of medicine in both North America and Britain. His experience as a young man and student helped develop his vision for a more united profession that would embrace the use of both clinical and laboratory science. He moved between Canada, Britain and the United States in his efforts to develop the profession in this way. He was born in Ontario, Canada, and was the son of an Anglican minister. He studied at Trinity College, Toronto, where he 'acquired a taste for science' and went on to study at the medical school of McGill University, Montreal. It has been noted that the breadth of Osler's outlook was engendered by his

peripatetic career.²⁵ His initial connection with medicine in London came in 1872 when he undertook his first year of postgraduate study at University College Hospital and St Thomas's Hospital before continuing his learning in Berlin and Vienna. His medical interests were broad: he studied physiology and pathology at University College and the Brown Institute, and he was interested in ophthalmology.²⁶ By 1875, at the age of twenty-five, Osler was back in Canada and had accepted the position of professor in the faculty at McGill.²⁷

Osler continued to research and lecture on a variety of subjects. He taught physiology, histology and pathology at McGill medical school, and parasitology at a local veterinary college. He also attended patients on the smallpox ward at Montreal General Hospital and developed his own private practice.²⁸ In his teaching, Osler remained committed to the importance of clinical medicine and observation. In 1905, he explained that 'I require no other epitaph...than the statement that I taught medical students in the wards, as I regard this as by far the most useful and important

work I have been called upon to do'.²⁹ His publications were frequent and wide in their scope. More general texts such as *The Principles and Practice of Medicine*, first published in 1892 and which reached its sixth edition in 1905, were imaginative and far-reaching. It remained the standard text on clinical medicine for the next forty years.³⁰ Texts of such scope were counter-balanced by investigations of specific illnesses, such as *The Cerebral Palsies of Children*, published in 1889, and *Angina Pectoris and Allied States*, published in 1897.³¹ By the time he returned to England in 1905, his written accomplishments and medical observations were widespread and had a long-lasting effect. As one commentator observed in 1949, Osler:

was the teacher, friend and fellow student to every seeker after the truth in medicine, to many of my and later generations who were brought up on his original textbook, who have read his monographs, and who have studied and pondered his addresses, he is still the wise friend, the clinical adviser, the unseen counsellor and the peacemaker when professional friction arises. His published addresses ensure the persistence of his influence.³²

His efforts towards the organization of the medical profession in America were significant, and shed some light on his desire to create an association of physicians in Britain. Osler's belief in the importance of bringing physicians together is evident from the various articles that he wrote on the subject. In 1885, he stated that 'by no means the smallest advantage [of medical societies] is the promotion of harmony and good fellowship'.³³ Osler was instrumental in founding the Association of American Physicians (AAP), and consequently had a clear idea of how a similar British organization should be formed.³⁴ According to Michael Bliss, Osler's biographer, those who formed the AAP had disagreed with the high-handed actions of the American Medical Association in its bid to become the governing body of the American medical profession.³⁵ The AAP was launched in 1885. Its membership was limited to one hundred members in order to add honour and prestige to the Association. It aimed to advance knowledge in medicine and to be free of medical politics and 'ethics' (meaning that members were not restricted by the formal codes of others). What mattered was whether a man 'had something to say worth hearing'.³⁶ It was this conviction, and Osler's experience with the AAP, which made the need for a British association of physicians obvious to him.

On his arrival at Oxford from Baltimore, Osler had documented his sadness, common among many US observers, at the lack of scientific training in medical education in Britain.³⁷ Historians have described his attacks on the state of British medical schools as 'scathing'.³⁸ He was not alone in his views—the founding members of the British Association shared them.

Osler was approached by Hale-White and Archibald Edward Garrod, Assistant Physician at Barts, primarily because his contribution to medical research and his connection with Clarendon Press. As well as being curator of Bodleian Library at Oxford, serving on the Council of the Royal College of Physicians (RCP) and being a member of the council of the British Medical Association, Osler was a member of the governing body of the University Press.³⁹ Osler 'threw himself into the matter [of the Association] with enthusiasm'.⁴⁰ He suggested that they ought to form a national association of physicians, along similar lines to the AAP, and let the journal be its official organ.⁴¹ Osler believed that medical societies helped 'to keep a man "up to the times"', and enables him to refurnish his mental shop with the latest wares'.⁴² In addition, he felt that a medical society, such as the Association, would also promote the generalist traditions of medicine in the face of increasing specialization and help to strengthen the profession. The idea of the Association, with Osler's backing, was widely supported by London physicians and fitted well with the style and organization of medical societies at the time.

The Association's *raison d'être*

The objectives of the British association developed in a different context, however. This was reflected in the official aims of the proposed Association for Great Britain and Ireland. First, it sought to promote internal medicine. The founders of the Association saw a need to defend general medicine at a time of increasing specialization but at the same time, they wanted to provide an opportunity to identify those practitioners who were felt to show great potential in research and share ideas amongst leading physicians working in different areas. The Association hence aimed to provide generalists wary of the increasing specialization of medicine with a forum for furthering their knowledge and maintaining their generalist stance at a time when many practitioners feared that Britain was falling behind other countries in the advancement of medical knowledge. For the Association and its supporters, it was felt that physicians should

maintain and strengthen their generalist traditions rather than embrace purely specialist research. To do this, the Association built on the long established tradition of demonstrating clinical cases but sought to ensure 'anybody could understand and discuss them'. Looking back on the early years of the Association, Robert Hutchinson, one of the founding members and Physician to the London Hospital, expressed his regret that increased specialization had meant the end to papers at meetings that all could understand.⁴³

Second, the Association aimed to promote 'friendship', meaning the opportunity to share with other physicians. This was considered to be of equal importance to the first aim of promoting internal medicine. Indeed, some members saw this as the Association's main purpose. A letter from the Honorary Secretary, Henry Letheby Tidy, in 1932, explained that 'the primary object for which the Association of Physicians was founded was to give members an opportunity of meeting each other'.⁴⁴ It was through the development of friendships and the creation of a forum through which physicians could meet and discuss their work that the Association sought to counter the isolation many physicians experienced. Those who were members would become part of self-defined professional group. The founders of the Association were therefore seeking to create an environment through which leading figures in medicine could meet and develop their relationships. As such, the Association was conceived as a mechanism to promote the attitudes and values of a self-identified elite of medicine.

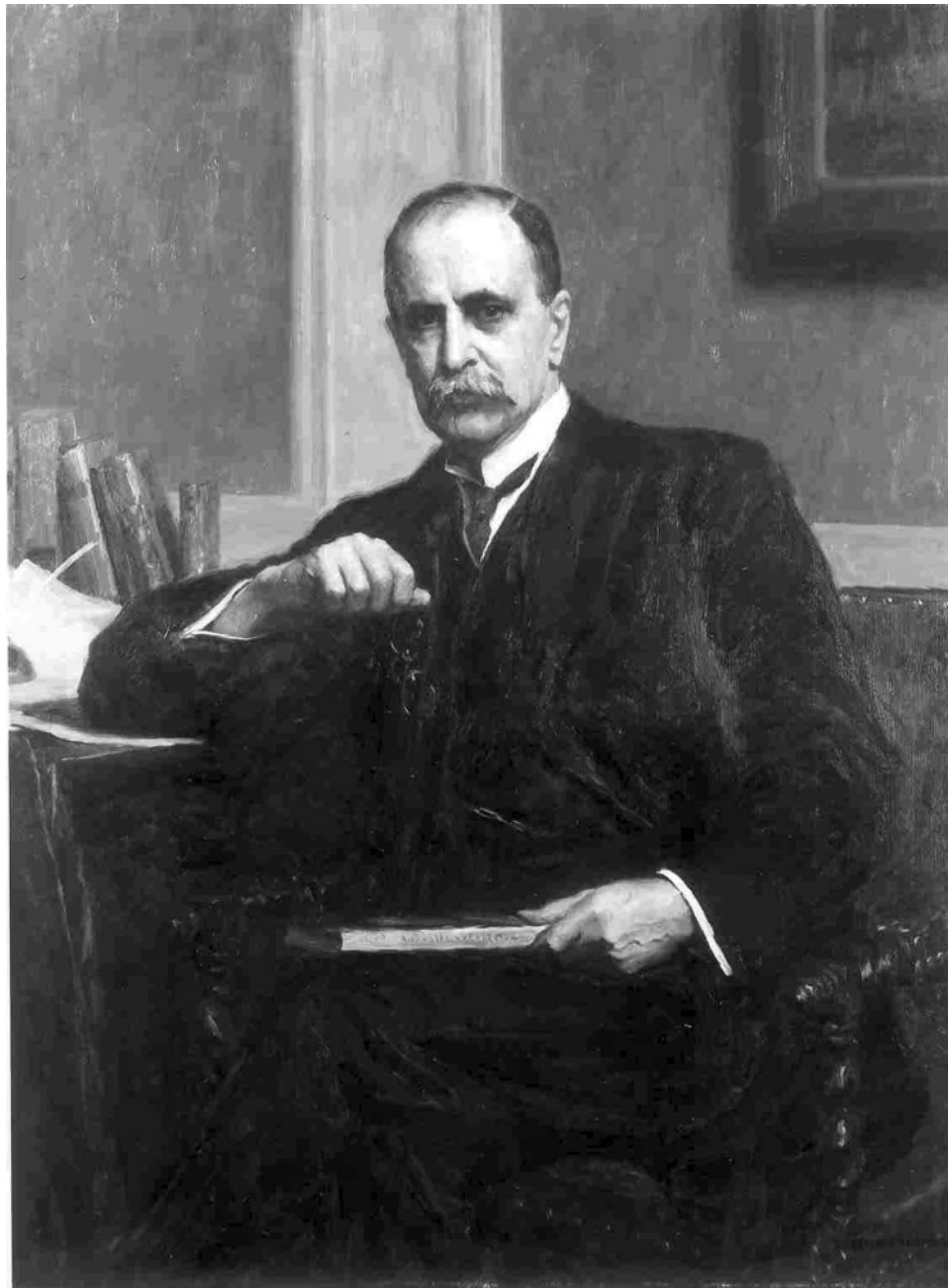
The restrictions imposed on membership, in part ensured by the imposition of entry qualifications, was fundamental to shaping the early identity of the Association. The draft scheme embodied in the Rules stated that the Association should consist of no more than 250 Ordinary and Honorary Members, all of whom were to be involved in teaching or research. General practitioners were to be excluded.⁴⁵ Younger men were to be encouraged to join. It was felt that this would ensure that maximum benefit could be gained from belonging to the Association. No inactive members were to be permitted. This was reflected in the rules of the Association. It was initially proposed that 'a member who is absent from four consecutive GMs shall cease, *ipso facto*, to be a Member of the Association'. Interestingly, this was the only rule that was contested when an amendment was moved to insert after the word meeting 'without due cause', but this was lost. The rule was passed as drafted because regular attendance was deemed paramount for the development of an effective and respected Association.

These restrictions imposed on membership reveal much about the objectives of the founding members. The rules governing membership highlight the importance the founding members ascribed to teaching hospitals and the new provincial university medical departments in the development of medicine. Only those who were considered to be actively advancing medical knowledge, or in the case of honorary members who had already contributed to its advancement, were invited to join. By limiting membership, it became a privilege to belong to the Association and conferred status in the same way as membership of London club did. By encouraging younger men to join, it allowed ambitious and talented men to be identified and socialized into the profession. In doing so, the Association would help maintain links between old and new and foster the 'gentlemanly' traditions associated with the London medical profession. The Association also provided a means through which contacts could be made with those who shared similar interests. At the same time, the founders hoped that the Association would also provide a forum to create a more dynamic and forward thinking section of the profession.

Originally, invitations and draft schemes of proposal were sent only to members of the medical staff of hospitals connected with recognized medical schools.⁴⁶ These men were believed by the founding members to be the elite of the profession and were felt to represent the most scientific and progressive sector of medicine. This rule was soon adapted, however. It was quickly realised that such a regulation would exclude worthy physicians that were on the staff of non-teaching hospitals. For example, the exclusion of Frederick Parkes-Weber, who specialized in the study of rare diseases at the Brompton Hospital for Diseases of the Lungs, and later at the Mount Vernon Hospital for Consumption, was considered to be 'unthinkable'.⁴⁷

Founding members

Seven distinguished physicians formed the committee that brought the Association of Physicians together. In May 1906, doctors Garrod, Hale White, Herringham, Hutchinson, Rolleston, Rose Bradford and Osler attended a dinner party at a house in Wimpole Street, London, where the formation of the Association was officially proposed. Analysis of connections and shared interests amongst the founder members reveals much about the basis of the Association and the connections amongst physicians in London at the time. Links



Sir William Osler (1849–1919), Courtesy of the Royal College of Physicians, 2427/61a–b.

can be seen in the position of members within their own professional strata, where they worked, and the stage they were at in their careers. As support for an association of physicians grew, it is evident that those who were invited to join shared the same desire to uphold professional ideals within clinical medicine.

In the account of the foundation of the Association given by Yates in 1952, the names of the founder members were described as ‘household words wherever medicine was studied and taught’.⁴⁸ All of them, with the exception of Osler,

whose career had led him to Oxford, held leading positions on the staff of various London hospitals, and were leading practitioners with established reputations and practices in the London’s fashionable West End. For example, Edward Archibald Garrod (1857–1936) was educated at Oxford and graduated with first class honours in the natural sciences in 1880 before attending Barts. By 1906, he was assistant physician to the hospital, was in charge of the children’s department and was lecturer in clinical pathology.⁴⁹ Wilmot Parker Herringham (1855–1934) was also a Physician at

Barts. In addition, he was consulting physician to the Paddington Green Children's Hospital.⁵⁰ The others held similar positions. William Hale White (1857–1949) was physician and lecturer in medicine at Guy's Hospital.⁵¹ Robert Hutchinson (1871–1960) had joined the staff of the Hospital for Sick Children, Great Ormond Street, and the London Hospital in the 1890s.⁵² By 1906, Humphrey Davy Rolleston (1862–1944) had obtained positions at the Metropolitan Hospital, St George's Hospital and the Victoria Hospital for Children, although his main connection was with St George's.⁵³ Finally, John Rose Bradford (1863–1935) had become Professor of Medicine at University College Hospital and Holme Lecturer on Clinical Medicine to the University College Hospital medical school.⁵⁴ All practised and taught medicine in the long established London medical schools, while Rolleston, Garrod and Herringham all had connections with Barts. All occupied the same professional strata. In addition, all worked in the same part of London (as did many of the Association's early members) and were known to each other through their institutional appointments and membership of professional bodies. All shared similar experiences of private practice and hospital consultancy.

The books and papers written by these men demonstrate their commitment to scientific practice. Osler's written achievements are well known. His British works written before 1906 included *The Cerebral Palsies of Children* (1889); *The Principles and Practice of Medicine* (1891); *On Chorea and Choreiform Affections* (1894); and *Cancer of the Stomach: A Clinical Study* (1900). In 1905, Rolleston published *Disease of the Liver, Gall-Bladder and Bile Ducts*, a book which reached its third edition in 1929.⁵⁵ Hale-White was 'a prolific author', completing many works including a *Textbook of Pharmacology and Therapeutics*. What had really established his publishing career were his *Materia Medica, Pharmacy, Pharmacology and Therapeutics* (1892) of which 26 editions were printed in his lifetime.⁵⁶ Hutchinson was the author of *Archives of the Diseases of Childhood* and *Diseases of Children* (1904).⁵⁷ Finally, among other things, Garrod wrote *A Treatise on Rheumatism and Rheumatoid Arthritis* in 1890.⁵⁸ All were actively engaged in clinical study and clinical pathology, with many of their books not only becoming standard texts but also embodying the latest scientific and laboratory methods. These values and connections were to be reflected in the Association.

The First annual general meeting

By early 1907, news of the intended Association had become widespread. In April of that year, for example, Osler in a letter to Robert Arthur Young, physician at the Middlesex Hospital, commented that 'I daresay you have heard that an Association on lines similar to the Congress für Innere Medizin in Germany has been organized for Great Britain and Ireland'.⁵⁹ Official letters of invitation explained that 'a desire has been expressed among many quarters that an Association should be formed for the discussion of purely medical subjects, which should be of national, and not of local character'.⁶⁰ Informal meetings were held in London, Edinburgh and Dublin, which confirmed interest in the proposed Association.⁶¹ Letters of invitation were sent out in July 1906 and were signed by twenty leading physicians who had emerged as the core representatives of the Association. These included Clifford Allbutt, then Regius Professor of Physic at Cambridge; Thomas Robinson Glynn, Liverpool University's first Professor of Medicine; and James Alexander Lindsay, physician to the Royal Victoria Hospital, Belfast, and Professor of Medicine at Queens University.⁶² Many of the twenty formed the first Executive Committee of the Association. Each of the men invited to join the Association came from the same social and medical milieu as the founders. Many were known personally to each other through their teaching and writing, and through their membership of other professional bodies or medical societies, such as the Royal Society of Medicine, to which most of the original London members also belonged.

The first Annual General Meeting (AGM) was held on Thursday and Friday, May 23rd and 24th, 1907, at the rooms of the Royal Medical and Chirurgical Society in Hanover Square. Two morning meetings and two afternoon meetings were held.⁶³ In line with the established traditions of British medicine, the papers at first were almost entirely clinical rather than laboratory-based.⁶⁴ For example, Tooth, senior physician at Barts, presented a paper on a middle-aged woman with polycythaemia; Buchanan, assistant gynaecologist at the Royal Infirmary Liverpool, described the case of a lady who was seized with acute abdominal symptoms, whose blood was found to contain a large excess of lymphocytes.⁶⁵ This clinical emphasis is not surprising: the founders of the Association were concerned with maintaining the traditional features of bedside medicine. At the same time, as these papers show, the Association and its members were not hostile to laboratory medicine but endeavoured to place it within a clinical context that emphasized the role

of the physician. The two were not always mutually incompatible. Interestingly, however, when discussing their memories of the first AGM several decades later those who attended noted that although they could not recall the subjects on the agenda, the novelty that 'we saw and heard the men who contributed the papers' remained the constant theme of their recollections.⁶⁶

The values of the Association are evident in the discussion that followed the papers. Just as with the presentation of clinical cases, members were able to discuss the findings and verify the evidence presented to them. Following the paper read by Tooth, there was a considerable debate between Osler and McLuitty, Acland, Garrod, Gibson, Parkes-Weber and James Barr. It emerged that although Tooth's case had considerably improved in appearance, the blood count had become nearer normal and the spleen had decreased in size under X-ray treatment, this could not be taken as a general rule. The other speakers could not record a similar experience.⁶⁷ The discussion following papers allowed for a practical evaluation of the findings presented. Theories and laboratory results could be compared to their practical application to medicine within a range of different hospitals and new conclusions drawn. This educational role was emphasized in the encouragement given to members following these papers that in future 'attention should not be concentrated' on histology alone, 'but that more effort should be made for an etiological classification'.⁶⁸

One of the ways in which scientific discussion was encouraged was through demonstrations of clinical cases after the morning meeting.⁶⁹ They gave members the opportunity to observe other people's findings, and to learn about new methods and other subject areas. For example, William Russell, senior assistant physician at Edinburgh Royal Infirmary, demonstrated the result of arterial sclerosis upon the clinical estimation of blood pressure. At the same time, Melland, house physician at the Manchester Royal Infirmary, presented microscopic slides of the blood from a case of leukaemia.⁷⁰ Physicians at the time were becoming more interested in blood and histological findings and the Association was active in promoting their use in research and medical practice.

The future of the journal of the Association was decided at the meeting of the Executive Committee, which followed the first annual dinner. The journal was to follow the traditions of clinical medicine and uphold the values that the founder members endorsed. It was agreed that the Clarendon Press should publish the new journal. The editorial board was made up of the founding members or

those closely linked to them. Osler was appointed editor-in-chief.⁷¹ Garrod, Hale-White, Hutchinson and Rolleston joined him on the board; four of the original seven men who helped create the new Association.⁷² They were joined by Sir John Rose Bradford (1863–1935). He was a Physician at University College Hospital and was a pioneer of the idea that all scientific research allied or ancillary to medicine should be brought into association with clinical practice.⁷³ The close connection between these men demonstrates that the journal was intended, just like the Association, to act as a force for promoting science in medicine as Osler and the other founders had envisaged. Twenty-six other members of the Association are listed as having contributed to the publication of the first edition of the journal, which by this stage had been renamed the *Quarterly Journal of Medicine (QJM)*.⁷⁴

The dinner

The value of meeting together in these early years can be understood from accounts by members who attended the first annual dinner. 134 members and guests attended the dinner which took place at the end of the first day of the two-day meeting.⁷⁵ According to Hutchinson, 'all dined together quite informally'. The spirit of friendship that the founding members had intended was already in the air.⁷⁶ Moreover, in a letter written in 1956 by Parkes-Weber, he revealed that what stood out in his memory was that 'all the members seemed very enthusiastic, both in greeting each other and in the discussion of cases' and that 'there was a great deal of hospitality shown by the local members to the visiting ones'.⁷⁷ John Hay, of the Liverpool Royal Infirmary, also commented that he would never forget that first meeting. For him, 'it was an exhilarating experience. The atmosphere was electric... For the young men, and I was one of them, it was a landmark in our lives. An epidemic of introductions'.⁷⁸

The chance of meeting together, especially at the annual dinner, cemented many friendships. From time to time, it also offered the opportunity to pick up 'interesting and even important odds and ends outside the official programme' and make important professional and personal contacts.⁷⁹ For example, at the 46th Annual Dinner in 1952, the president, D.A.G. Yates, who had been elected a member in 1915, spoke of a conversation that had taken place between himself and William Hale-White, one of the founder members. It had occurred during Yates's early days in the Association and had helped secure

the friendship between himself and Hale-White. Both men shared an interest in medical history. When Yates mentioned a subject over dinner in which he was particularly interested, Hale-White insisted on taking Yates to his home to give him a reprint of an article he had written about a similar event.⁸⁰ The annual dinner was therefore fundamental in helping to fulfil the second aim of the Association. It allowed physicians to come together and discuss both work and matters of leisure.

The establishment of the Association and the *QJM* cannot be underestimated in terms of its impact on bringing together established consultant physicians and new, young and talented men who were making a good name for themselves. The inclusion of such men and the style of papers presented at the early meetings demonstrate how the Association's founders were seeking to foster a particular professional identity, one that merged the bedside with the benchside. The Association's aims to promote internal medicine and friendship reflected contemporary fears about the nature and status of British medicine and the perceived divisions within the medical profession as well as the desire for unity and solidarity. Of all the accomplishments Osler had made while at Oxford, he considered the Association and the *QJM* to be among his finest and most worthy achievements. On 28 May 1915, Osler described the past ten years that he had spent in England in his diary. In his entry, he considered that:

I have not done much in the profession here but I have done three useful things, or better, helped to: 1) the Association of Physicians; 2) the Quarterly Journal of Medicine; 3) the Historical Section of the Royal Society of Medicine.⁸¹

Growth, 1907–1914

In the years immediately following its foundation, the Association grew steadily in strength and reputation as more physicians accepted invitations to join. Individual members would propose an eligible physician for membership. Usually such men were from their own hospital or university. The Executive Committee would then select those they considered the most promising based on evidence of what the nominee could contribute to the Association. Personal and professional networks were hence important, not only to shaping the Association's membership and identity but also to the furtherance of individual medical careers.

As the Association grew, it worked to extend its national appeal. Between 1907 and 1914, it held meetings in the large university cities of London,

Edinburgh, Dublin, Liverpool, Glasgow, and Cambridge.⁸² The number of papers read gradually increased as well: from ten papers in 1908, the number rose to twelve in 1911 and to eighteen in 1914.⁸³ This was a direct result of an increase in the submission of interesting papers as the Association's reputation grew. The obvious development of the content of meetings was matched by the gradual rise in the number of members. As one member wrote in 1956, 'the Association at first was, of course, much more limited in numbers than it is now'.⁸⁴ The original limit placed on membership numbers—250 Ordinary Members—was designed to maintain the Association's exclusiveness, and therefore its status, for the purpose of attracting those at the top of the profession among whom it was felt links could most usefully be forged.⁸⁵ By 1914, because of the high esteem in which the Association was held, the number of physicians seeking to join far exceeded this limit.⁸⁶ Limiting numbers was also a way of maintaining the traditional values of the Association by inviting only those who shared the desire to sustain the collegiate features of medicine and of educating new members in the ways of the old. The inclusion of a large number of new or more radical thinking members would have forced a considerable change in the values of the Association.

Networking provided an essential incentive for membership. Older members were given the opportunity of meeting young men who had been singled out to become leading lights in the profession. In 1914, for example, thirteen new members were carefully selected. These included George Graham, who would have been thirty-two years old when he was invited to join. He had been educated at Trinity College, Cambridge and Barts. He went on to become physician to the Royal Northern Hospital and the East London Hospital for Children, as well as being Consultant Physician to St Bartholomew's Hospital, and wrote *The Pathology and Treatment of Diabetes Mellitus*.⁸⁷ Similarly, Alexander Edward Gow, who became a member in the same year as Graham, was only thirty when he was elected. He was also educated at Barts and went on to have a high-profile career as senior physician to the hospital and was co-author of *The Essentials of Medical Diagnosis* with Lord Horder, a member of the Association since 1908.

The social side of the annual meetings was also part of the Association's appeal. The merriment experienced at the first meeting continued and was enhanced as more members were introduced to each other. The kind of camaraderie between members was apparent from these early years. Hay highlighted the enjoyment shared at meetings when describing a photograph taken at the annual

meeting in 1913. In discussing the photograph in a letter to another member many years later, he wrote 'I do remember the photograph to which you refer... Sir William Herringham had been having a kind of wrestling match with "Pussy" French'.⁸⁸ The friendship, mischief and sense of fun shared by members is evident. "'Pussy" French' to whom he refers was actually Herbert French, lecturer in clinical medicine and tutor at Guy's Hospital.⁸⁹ He, like Hay, had become a member of the Association in 1908. The annual meetings provided an opportunity for socializing and enjoyment that had a great appeal to members. It gave them the opportunity to meet with likeminded people and boosted the prestige and honour of belonging. Moreover, the social element helped to foster the identity of members and their professional values.

Between 1907 and 1914, the selection of high profile presidents, through nomination by the Executive Committee, helped promote the reputation of the Association. Four of those who took on the role of President in these years had already been knighted in recognition of their achievements. In 1908, for example, Thomas Fraser accepted the title of presidency of the Association. He was Professor of Materia Medica and Clinical Medicine at the University of Edinburgh. He was also Medical Adviser to the Prison Commission of Scotland and between 1898 and 1900 was President of the Indian Plague Commission.⁹⁰

The early members of the Association illustrate the emphasis placed by the Executive Committee on inviting physicians from all over Britain and Ireland to join. Of the 242 members in 1908, twelve were based in Liverpool; nine in Manchester; sixteen in Edinburgh; seven in Glasgow; twenty in Dublin and four in Cork. Members also came from Cambridge, Birmingham, Leeds, Newcastle-upon-Tyne, Belfast, Bath, Bristol, Oxford and Sheffield. Not only does this highlight the shifting geography of medical education, it also reveals how the Association worked to extend its influence and become a national body. Nevertheless, the highest proportion of membership continued to come from London: eighty-nine members worked and lived in London. This metropolitan dominance reflected the position London occupied in the institutional structure of medicine. However, by extending its membership, the Association had succeeded in bringing 153 physicians from outside London together. Between 1909 and 1914, this trend continued, with another thirty-six members from outside London invited to join to fill the quota of 250 members, or to replace those that had left. This was in comparison with twenty-two new London-based members. For those outside London, membership of the Association

added to their reputation and status. At the same time, all members benefited from professional networks that the Association gave access to and in part helped create.

In the first years of the Associations, the social importance of the meetings was quicker to develop than the scientific content. It took several years for the number and quality of papers to build up to a level of 'excellence' sought by the founding members. At the first AGM, for example, only five papers were delivered and three demonstrations given. These papers were essentially clinical in nature and mirrored the practices of presenting cases common in many hospitals and medical schools. On the face of it, this would support the argument made by the historian Lawrence that:

Between about 1850 and the Great War, many senior British physicians, particularly those with hospital posts in London, employed a vocabulary which routinely invoked science as the foundation of medicine but which prescribed for science only a limited role in clinical practice.⁹¹

However, far from focusing on clinical observation regardless of the development of science, the papers show clear efforts to demonstrate the benefit of scientific methods in the diagnosis and treatment of cases. These included, for example, the study of a patient's blood to determine abnormalities. Observation was perceived by physicians to be essential, but this was not necessarily in dispute with the fact that laboratory science could aid diagnosis and treatment. In the first decade of the twentieth century, the practical approach of the Association to the introduction of laboratory science into medicine was a progressive one. Whereas the Association upheld the traditional values and authority of medicine, this was not at the expense of allowing British medicine to fall behind that of other countries.

The subject of the papers delivered at the early meetings of the Association reflected the changing fashions and developments in Edwardian medicine. For example, in 1907 papers that would now come under the specialist heading of haematology dominated the scientific business of the meeting, reflecting the role of growing role of the laboratory in investigating blood. By 1911, this was changing as cardiovascular problems became a popular subject for discussion. The discussion of such subjects was essential in the promotion of internal medicine because it allowed physicians to learn first-hand about the latest developments and discoveries. If laboratory science potentially threatened

the generalist approach to medicine as individuals focused increasingly on particular areas of research, the discussion of developing trends allowed members of the Association on the one hand to remain generalist in their outlook and on the other to be up to date in their knowledge. The Association was, as a result of its traditional values, generalist in nature but, as evidence from papers given during its early years reveals, this was not at the expense of laboratory or 'science' based medicine.

War and the Association, 1914–1918

The First World War disrupted the work of the Association. Many of its members were posted abroad to serve as physicians with the army, navy or air force. Members of the 1914 Executive Committee of the Association, such as Professor George Redmayne Murray, served overseas.⁹² Others remained in Britain but were removed from their usual working environments. Byrom Bramwell, for example, served as consultant to the London Command between 1914 and 1918.⁹³ Sir Wilmot Parker Herringham, the Honorary Secretary of the Association in 1914, was made Consulting Physician to Government Headquarters and later the Third Army from the first battle of Ypres to the end of the War.⁹⁴ Whereas the general meeting in 1914 was barely affected by the forthcoming War, the next four scientific meetings were cancelled due to the lack of members available to attend and the general disruption that was taking place in everyday life. Only business meetings were held, at which the Executive Committee discussed the finances of the Association and of the *QJM*.⁹⁵ Publication of the journal also ceased during the war. The importance of medicine and the medical profession, however, was enhanced during the war years and the effects of this were clearly seen in the Association in the interwar period.

War raised the status of medicine and underlined the importance of healthcare. It was in 1918, for example, that Lloyd George proposed that Britain under his Liberal government should be 'A Land Fit for Heroes'. The health of men fighting on the frontline was a major factor in this changing attitude. Deaths through combat did finally overtake deaths caused by disease but only marginally. Typhus, for example, had killed 150,000 by 1917.⁹⁶ Immunization became more commonplace during wartime. For example, the British and American army adopted the policy of immunizing all soldiers sent abroad against typhoid. Although immunization was extremely unpleasant, it dramatically

reduced the death rate from typhoid.⁹⁷ The adverse effect of the Great War on the health of returning soldiers was also clear. The psychological impact of combat as well as physical trauma was increasingly recognized.⁹⁸

When the members of the Association returned from the war, they were faced with more changes in the identity of the profession. The Association, which had provided a sense of solidarity before 1914 and helped to maintain the *status quo* in terms of medical tradition, now went on to provide a means of fashioning a post-war identity for the physicians whom belonged to it.

The interwar Association

The absence of meetings during the First World War had a profound effect on the progress that had been made towards ending the isolation between doctors and medical establishments. Improvements in diagnosis, the treatment of war wounds, and in emergency medicine during the war had seen advances in medicine. Osler was adamant for the Association to resume its meetings in the wake of wartime experiences. In 1919, he declared that if a general meeting was not called soon 'we shall forget what we look like'.⁹⁹ It was considered essential to re-establish the identity of members and to forge the pre-war networks that had been damaged by the absence of meetings. Meetings were resumed in that year.

The 1919 meeting was held at the Royal Society of Medicine in Wimpole Street, London, a central meeting point where attendance figures had always been higher than those of provincial meetings. One hundred members of the Association attended. This was a high figure in comparison to pre-war meetings: for example, seventy members had been present at the AGM in 1912.¹⁰⁰ This was a testament to the fact that members were keen for the Association—and for the practice of medicine—to return to normal. A new Executive Committee was elected, which included Norman Moore, who was elected president of the Association. He was also president of the RCP and physician to Barts and was therefore sympathetic to academic medicine and to the values held by London practitioners, which provided a clear signal to members and other physicians that the Association was to continue in the same way as it had done before the war.¹⁰¹

The 1919 meeting reflected the immediate importance of wartime medicine to members. The growing use of diagnostic technology after the war, such as X-rays and the electrocardiograph, changed many of the diagnostic methods used by clinicians.



Dr A.G. Barrs, one of the original founders of the Association, Courtesy of the Royal College of Physicians, 2434/281(D).

Progress in these areas was reflected in the papers given at the initial post-war AGMs.¹⁰² From 1914, serious injuries to limbs were the major type of wound for servicemen. Consequently, there was an expansion of orthopaedics as a powerful specialist field within military medicine and, after the war, within civilian medical practice.¹⁰³ Many members of the Association had been at the forefront of these developments. At the meeting in 1919, for example, John Nixon, Consultant Physician to the Royal Army Medical Corps, gave a paper on the subject of shell wounds of the chest and discussed the chief indications of the need for early operation.

Fortescue-Brickdale, another military physician, gave details of the late results of operating on shell wounds of the chest. Professor Gibson, Nuffield Reader in morbid anatomy at Oxford, reported on the study of septic thrombosis following war wounds and a paper was also given by George Herbert Hunt of Guy's Hospital on 'The treatment of patients suffering from the late effects of gas poisoning by continuous inhalation of oxygen'.¹⁰⁴ However, these papers did not go any way to demonstrating the relevance of wartime discoveries to peacetime. The impact of wartime advances on interwar medicine has been questioned by historians.

Many of the wartime innovations were the result to specific problems encountered during the First World War and were not immediately translatable to peacetime. For example, methods devised to treat shell wounds had little practical application. However, members could only present new papers based on their work over the past few years. Many members had not yet settled back into the work that they were pursuing before the war at a time when new work and reform was hampered by the need to restore and rebuild.¹⁰⁵

This is not to say that the war did not have an impact on the scientific business of the Association in a different way. Once members settled back into their normal positions within hospitals and universities, the subjects included in annual meetings became more diverse. They reflected the continuing specialization of medicine and the impetus that war had given to this process. The Association was adapting and moving away from the extremes of its early generalist nature, although it remained true to its belief in the traditional values of medicine. Consultant physicians were facing a new range of assorted challenges and the Association began to accept the need to recognize more specialist areas as they developed. For example, neurological disorders attracted considerable interest. At the 1920 meeting in Manchester, two papers were read on neurology. The first related to nervous disorders and the second explained 'The physical basis of neuroses'. Post-operative 'mania' was also a subject that came under discussion at this meeting.¹⁰⁶ The papers discussed at meetings, and those published in the journal, not only reflected these changes but also allowed physicians working in the major hospitals and universities to gain an understanding of new developments in medicine.

There were other reasons for the increased discussion of specialist areas of medicine by the members of Association. The encouragement given to medical research in the years immediately following the war contributed to these changes. After 1918, through the support of the Medical Research Council (MRC), established in 1913, and changes in the perception of research, which the Association helped to stimulate, greater importance was placed on medical research. At the same time, a shift in mortality patterns helped focus this research into the growing problems of cancer, heart disease and diet, which consequently had an impact on the papers given at the Association's meetings. From 1921, papers, for example, on 'Factors of diet influencing the production of normal and hyperplastic thyroids of dogs and the extension of this knowledge to the treatment of exophthalmic goitre' began to be read at meetings.

Diabetes also came to the fore as a popular subject for discussion as a result of growing awareness about the links between diet and health. Greater emphasis was also directed to cardiology. Cancer also became a subject that was discussed regularly; a reflection both of the growth in the number of people affected by the disease, better diagnosis and greater investment in research. In 1925, for example, one of the members reported his experience of 'cases of cancer treated with emetine and a violet preparation'.¹⁰⁷

The type of papers presented at annual meetings reveal that although clinical observation continued to remain important, there was an increasing emphasis on biochemical and laboratory sciences in the understanding and framing of disease. Moreover, the interwar years also represented a period of growth in specialties that were embraced by the Association. Members valued meeting together and discussing these developments because it provided a way of unifying increasingly diverse areas of medicine. Thus, the identity that the post-war Association developed was one that embraced both scientific understanding and specialization. While members were unified in their support of specialist research, they also maintained their continued interest in all areas of medicine.

Increased recognition by some members of the Association of the need to bring more of those working in newer specialist fields under the umbrella of the Association is reflected in the variety of meeting places and the emphasis on new membership in this period. In 1920, Manchester was the chosen venue for the meeting for the first time. Birmingham hosted it in 1921; Bristol in 1924; Newcastle in 1926, and Leeds in 1934. This geography of meetings mirrored the emergence of new civic medical schools and universities and helped the Association extend its national appeal. It was also important that the Association continue to represent all areas of medicine and teaching establishments throughout the country in order to maintain the identity and status of existing members and the Association's reputation.

Despite these efforts at expansion, questions were raised in the late 1920s about the need to increase the number of young members. Some members argued that the inclusion of such men, and possibly women, would help make the Association more representative of those who would one day rise to the top of the profession and help widen social and professional networks. Those promoting change thought that 'this question is at least worthy of full consideration in the wider interests of British medicine'.¹⁰⁸ However, other members argued that an increase in younger members would

result in the exclusion of more Senior Members, in particular some of those who had been members since the Association's foundation. For some more conservative older members, it was feared that an influx of younger men with different ideas about medicine would threaten the *status quo* and the traditional values of the Association. A deadlock ensued between those who felt that the Association needed new blood to remain true to its aim of promoting the knowledge of internal medicine, and those who feared that any large increase in membership would destroy the Association. The debate on this subject lasted from 1927 to 1929. In 1927, Henry Tidy, then Secretary of the Association, entered into correspondence with Claude Trautgen of the Association of Surgeons of Great Britain and Ireland about the categorization of members. He wrote:

I notice that you have "Senior Fellows" the total number being only about 50, although apparently they are not limited. Is it possible to give any estimate of how many of these attend the meetings? Our own attendances run from 100 to 150, and we are rather of the opinion that any increase in this number would make the arrangements for a meeting much more difficult. It is possible that Senior Members do not attend in any number, and if this is so we might adopt your plan. Would it be possible for you to let me know what your usual attendances amount to, and how many of these are Senior fellows?¹⁰⁹

In the end it was decided that a category for 'Senior Members' (also referred to as Extra-Ordinary Members) should be created. Those placed in this group could attend meetings but were not entitled to vote.¹¹⁰ The number of Ordinary Members was increased to three hundred to make room for younger members while allowing Senior Members to remain as much a part of the proceedings as possible. As one member wrote in 1928:

While the policy of the Association should continue to be the inclusion of the best representatives of the rising generation of physicians, this need not be to the exclusion of such of the older members as feel a living interest in the proceedings and journal of the Association.

In spite of the apparent acceptance of increasing specialization in medicine, the Association

continued to pursue its commitment to generalism. Scientific meetings did reflect the changes that were occurring in medical research but change was kept to a minimum. This was the result of the belief that the status of physicians still rested on the pre-war traditions of medicine. The annual dinner continued to be considered of the uttermost importance because it was fundamental to the building professional relationships. In the Association, the importance of networks and the identity of physicians as gentlemen with a general knowledge of medicine remained strong.

War work

The Second World War, like the war before it, inevitably caused disruption and change for individual members and for the Association. In 1952, Yates, described some of his memories of the Association in those years. He remembered that:

In 1940 the meeting was in London and I remember well coming down to breakfast on that Friday morning to hear the wireless booming out the news that Hitler had invaded the Low Countries during the night, and it seemed evident that our way of life both as an Association and as individuals would be seriously interfered with. It was.¹¹¹

The increased responsibility placed on members of the Association was felt from the beginning of the war:

At that meeting in 1940 many members of the Association seemed to have taken an additional dignity and importance conferred upon them...by the uniforms which they wore. There were generals, colonels, group-captains and wing-commanders in great profusion...indeed the sight of so many members in uniform was perhaps a sign of the increasing importance of the role of the physician in the following years of the war.¹¹²

However, in contrast to the First World War, the Association cancelled only one of its annual meetings. This demonstrates both the importance of the meetings to members and a grim determination to continue life as normal, reflected by the decision to continue to hold meetings in London throughout the war. This is significant for two reasons. First, it shows the strength of London in the Association and British medicine. Second, it highlights the determination of members not to give in and move

out of the London. It was only on 'the urgent appeal of the Government that all travelling should be curtailed' as a result of the threat from V1 and V2 rockets and because 'other similar meetings had been cancelled' that the Executive Committee agreed not to hold the annual meeting in 1944. The severity of the situation is made apparent by a note that was made underneath the minutes of the committee's discussion by the secretary Henry Tidy, consultant at St Thomas's Hospital, once the war had ended. In it he wrote: 'during this meeting, flying bombs were falling continually. The official report of the Ministry of Home Security said, after the War, that this was the most disastrous afternoon of the whole campaign in the West End'.¹¹³ More than ever, the social and scientific value of the Association was perhaps less important than the professional role it played in maintaining peacetime norms.

Papers discussed at annual meetings during the war reflected the pressures experienced by doctors. In 1940, for example, Arthur Hurst, consultant in charge of the neurological department at Guy's Hospital, showed a film on 'War Neuroses'. The film, which had been made between 1917 and 1919, had been reprinted because it was thought that it would be unfortunate if the lessons learnt in the diagnosis and treatment of neuroses were forgotten and had to be slowly re-learned. This highlights the limited impact of the First World War on interwar medicine. By 1941, injuries caused by war became a focus for discussion. One example of this is a paper on 'Renal failure in crush injuries' in which observations of patients who had been buried under debris were considered. However, the most significant development in the nature of wartime papers was a considerable shift in focus towards diet, the effects of rationing, and an early emergence of 'social medicine'. The 1930s had seen a growing interest in nutrition, which was heightened by the effects of the Second World War and the concerns raised by evacuation. In 1941, for example, E.M. Widdowson, from Cambridge University's Department of Experimental Medicine—possibly the first woman to deliver a paper to the Association—gave a paper on rationing. In her experiment a diet was devised which was biochemically proven to be satisfactory and 'which it was considered that this country might aim at providing in a real food crisis'. All foods were severely restricted except brown bread (reinforced with calcium carbonate), potatoes and other vegetables. Five adults lived on the diet for over three months. The resulting observations were that the diet contained generous amounts of protein, calcium, phosphorous and iron, and of vitamins B

and C. By the end of the experiment, the subjects were reported to be in excellent physical condition.¹¹⁴ What the paper reveals is the difference between the reactive observations made in papers after the First World War and the proactive and exploratory nature of the discussions between 1939 and 1945. Unlike the earlier conflict, many of the papers given to the Association during this period were the result of the clinical and medical situation members encountered.

During the war the attitude of members was very much 'business as usual'. The majority of scientific discussion at the meetings continued to focus on a variety of subject areas. Medical research did not stop because of the war and was actively encouraged by the government. Britain, it was thought, needed to be running at maximum efficiency and medical research was to play a large part in achieving this. Of twelve presentations given in 1942, only one of them, on the subject of 'Immersion foot and allied conditions following exposure to cold', was influenced by the immediate crisis. The majority of papers at this time continued to focus on the heart, kidneys and the blood. This reflected the importance that scientific research now played in the development of medicine. Physicians were no longer relying on wartime clinical observations, but were actively seeking answers to the questions that biochemistry and other sciences raised. The continuation of discussion of normal subject areas shows the need felt by members to continue sharing new scientific research from as many specialist areas as possible in order to maintain the general nature of the Association.

The business of the Executive Committee also continued as in peacetime. Towards the end of the War, time was spent considering issues such as the possibility of having a joint meeting with the AAP. This was most likely inspired by the need felt for cooperation between allies and would have been influenced by American participation in the war effort. Britain and America were brought closer together through the crisis and at least until the end of Lend-Lease in 1945 a sense of friendship was apparent. In 1944, the President of the AAP, Colonel William S. Middleton, of the United States Army Medical Corps, was nominated to be a Foreign Honorary Member of the Association. As a result of this link a joint meeting between the AAP and the Association was suggested. It was proposed that 'the American Association was the parent body of the Association of Great Britain and Ireland' and that therefore it would be proper to accept the invitation to be guests of the AAP, and that the first joint meeting should take place in Atlantic City in 'the year following the cessation of the hostilities

in Europe'. However, the joint meeting was never held.¹¹⁵

All was not business as usual, however. The Association faced increasing problems remaining a generalist society in the face of increasing specialization, a trend accelerated by war. The *QJM* was failing to succeed in its objectives to serve the top ranks of the profession on a general level. In 1944, the view was expressed in the second meeting of the Executive Committee that there was widespread dissatisfaction with the journal. It was felt by many members that the *QJM* had become too rarefied, that it did not sufficiently serve as a resource for the consulting and teaching physician. It was explained that the papers printed tended to be highly specialized and largely biochemical in nature; that the kind of paper which should appear in the *QJM* was now printed in the *Lancet*, *BMJ*, or in one of the specialist journals. It was also argued that the *QJM* was failing to represent the nature of British medicine, in the sense in which the *Archives of Internal Medicine* (the journal of the AAP) was representing American medicine. In addition, it was noted there was a complete lack of clinical work 'in spite of the large amount of good clinical work printed elsewhere'. This clearly shows that divisions existed in the Association between those who embraced the changes that were occurring in medicine and those who felt uncomfortable with them. It seems that most members, while welcoming the benefits that laboratory science brought, were not ready to allow the traditional skills of the profession to be taken over by biochemical science. It was felt that a Board of six editors was a mistake: fears were raised that it might frighten off possible contributors, exercise too skilled and destructive criticism, and lack the same personal concern for the journal that a single editor would have.

Although these points were based on the observations of members, division between those who wanted the Association to retain its generalist nature and those who welcomed discussion of more specialist research was evident. The President at this time, Francis Fraser, a very significant figure in wartime medicine, gave possible reasons for the decline in the relevance of the *QJM* but failed to tackle the problem of how specialization could be dealt with by the editors. He agreed that the number of papers submitted had been falling since 1938, that invitations to write papers were inappropriate because potential authors were busy as a result of the war, and that 'the dullness of the papers at the moment was due to fashion, which at present is biochemical: it has happened before and will cure itself'.

However, he did admit that 'it would be unsafe to assume that the present defects in the Journal will spontaneously disappear after the war'.¹¹⁶

While recognizing the need to address the issues facing the *QJM*, Fraser was also aware that making any major changes to either the Association or the journal at this time would only damage the traditional generalist foundations on which the Association was built. Fraser felt that those returning from war would not be happy to discover that such alterations had been made in their absence. He argued instead that a single editor would be more appropriate than an editorial board, and that the solution to the problems lay in the membership of the Association. Fraser asserted that younger men should be encouraged to contribute to the *QJM* and the policy of electing men who were active researchers as members was the way forward.¹¹⁷ The emphasis placed on contributions from younger members and Fraser's failure to tackle arguments about the specialist nature of papers reflects his awareness of the complexity of the issue raised by specialization and the inevitable affect that this was having on the Association and its journal. To point this out would have further irritated those who were against this happening. The question of how to ensure that a generalist Association and its journal remained relevant to profession that was increasingly being sub-divided into various specialties remained unresolved.

Specialization and the Association, 1946–1969

The post-war period saw considerable changes to the structure of medicine in Britain. The creation of the National Health Service not only altered the professional landscape of medicine but also ushered in a hospital building programme. Medical research started to permeate every aspect of medical practice as increasing investment was made in biomedical research. Modes of scientific practices based around institutional cooperation and collaboration were coming to define research. Institutes set up before the war experienced a period of growth; new institutes were established both by governments and by pharmaceutical companies. In the two decades following the war, medical research contributed to a series of advances that helped fuel the belief that the prevention or cure of all ills was possible. This was matched by faith in the application of science and technology to progress and improvement. Medicine, which before 1940 had retained a predominately generalist ethos, became gradually more fragmented and specialized.

Changing disease patterns, particularly those related to lifestyle, made new medical procedures necessary. The introduction of antibiotics, immuno-suppressive drugs, and technical innovations saw medicine expand into new areas considered impossible in the interwar period. New methods were introduced. The double-blind randomized control clinical trial (first developed in connection with a trial of streptomycin in 1946) and the application of epidemiological methods to investigate clinical conditions, which extended clinical medical research, became the new gold standard. New measurement techniques and new treatments were devised, some of which, such as nuclear medicine, were spin-offs from the war. Biomedical research continued to extend the ability of clinicians to diagnose illness and examine the disease process. New diagnostic methods—including computer tomography, magnetic resonance imaging and fibre-optics—allowed doctors to see into the body in a different way.

Between 1946 and 1969, the Association was forced to look for ways to bridge the gap between these changes and the increasing pace of specialization in medicine and the relevance of its generalist meetings. In 1946, for example, the Executive Committee began to consider forging links with specialist societies. Most members of the Association were now also attending meetings of whichever society represented their own area of research. Other societies, such as the Gastro-Enterological Club, had already suggested to the Executive Committee that the meetings of various societies could be held in the same place in the same week but this idea had been strongly opposed by the Association. In a letter from J.L. Hardy of the Gastro-Enterological Club, he described how:

In the days of Witts, the proposal... received very strong criticism. We were told that holding meetings so near the time of the Association were depriving the Association of topics for discussion of general interest on matters gastro-enterological.¹¹⁸

By 1946, the attitude of the Executive Committee had shifted. As result of the changing nature of medical education and practice, and the perceived need to ensure the ongoing survival of the Association, the Executive Committee recognized that an awareness of the value of specialization was necessary for the Association's future. Members now suggested that a joint meeting should take place in London every five years. There appeared to be two ways in which this reform might come about. The first was to balance the programme of each meeting

by getting each specialist society to contribute at least one paper 'of good content', 'preferably a paper which illustrates an advance in that church of medicine'. The second was to devote one part of the meeting to a discussion of educational or research methods 'which would be of interest to all physicians'. This was seen as an opportunity for hearing what was happening in different medical schools.¹¹⁹ The other societies were enthusiastic. For them, it offered a way of ensuring that members were more likely to be able to attend meetings and because it was a way of further sharing knowledge.

In 1951, a special subcommittee of the Association, Chaired by Leslie John Witts, the first Nuffield Professor of Clinical Medicine at Oxford, was formed 'to consider the future of the Association and to make recommendations' in order to include members and papers from all fields of medical research. The subject was considered under four headings:

1. Criteria for membership;
2. Size of the Association;
3. Relationship to special societies—Annual Meeting;
4. Continuity of policy'.

However, a general reluctance to accept change continued to characterize the Association. It failed to adapt, possibly because many of its members were set in their ways but also because some had come to perceive the Association as irrelevant. For some physicians, the Association had failed to keep up to date with specialization, ensuring that some members had become content with its status as an elite club. Whatever the reason, the Executive Committee found no reason to alter the existing criteria for membership as embodied in Rule 2, 'Physicians actively engaged in the teaching of medicine, or in research', provided that the widest interpretation was given to the word 'research'. It was felt that the number of members should not be increased to make room for representation of a greater variety of medical specialties if the Association was to continue to meet in centres outside London. Furthermore, an increase in numbers would have threatened the exclusive nature of the Association. However, it was acknowledged that there was a need to increase the limit on Ordinary membership so that the average age of entrants could be lowered: too many promising physicians were being excluded or had their election to membership delayed. It was decided:

1. That all Ordinary Members, with the exception of Original Members of the Association, should resign on reaching the age of 65;
2. That the total Ordinary Membership of the Association be limited to 350;

3. That Extra-Ordinary Membership be abolished, but that, for the first 15 years of Membership only, a Member be required to attend 1 in 3 meetings as under Rule 20, but that after that period he be exempt.¹²⁰

It was anticipated that these changes would make more room for new members.

With regard to meeting with specialist societies as a means of bringing the Association more into line with specialization, the Executive Committee was not convinced of the practicability of joint meetings. Joining with other clubs or societies would have damaged the position of the Association, but this had to be balanced against meeting claims that its generalist nature was rendering it redundant. One solution was for the establishment of symposia on suitable subjects. It was felt that this would not require any major changes to the structure of the Association, but would allow it to 'usefully consider the implications and incorporation of new and special work into the pattern of medicine as a whole' while 'representing the outlook of the general physician in the broadest sense'. Symposia could perform this valuable function without being detrimental the Association's identity.¹²¹

Conflicting views among members, and a lack of activity on the part of the Executive Committee, ensured that debate about how best to reform the Association dragged on for another two decades. Although it was recognized that the structure and nature of the Association had to adapt to the new, post-war medical and professional reality, the desire of the Executive Committee to maintain the features of the Association that formed its unique identity created a reluctance to accept any of the suggestions put forward. It was thought that change and modernization might jeopardise the status of the Association and therefore have an adverse impact on the membership. A general inertia about the future of the Association among many of those who were less involved in decision-making process, and with few members actually pushing for change, also contributed to the slow nature of reform. Although symposia were introduced at annual meetings just after the Second World War, their popularity and impact was minimal. Limited change was clearly not enough for the Association to incorporate the fast changing nature of medicine. Fresh attempts were needed to bring specialization within the generalist nature of the Association.

By 1964, the Executive Committee was still discussing the need to introduce papers that were not of a general clinical nature. In this year it was confirmed, in a statement on the conduct of the scientific business of the Association, that members would be encouraged to give or introduce papers

'not only of general clinical interest but also of specialised or laboratory nature provided that they were relevant to the advancement of clinical medicine'. The decision was made in order that the scientific excellence, and therefore the appeal, of the Association would not be lost. It was also decided that the election of new Ordinary Members should take into account the need for the Association to include amongst its members representatives from 'the full range of clinical specialties in order that the Association maintained its object of advancing clinical medicine in its widest sense'.¹²²

Despite these changes, the Association remained out of step with the pace of specialization. Practical steps towards change were slow, mainly because the Executive Committee did not want to compromise the Association's traditional values. For example, when Charles Newman, Physician at King's College Hospital and later Dean of the Royal Postgraduate Medical School, suggested that either more than one scientific meeting could be held a year to increased number of specialties were represented, or that papers should be shortened to ten minutes, the Executive Committee unanimously agreed that the proposal would be against the Association's best interests. The Committee argued that there were already numerous alternative societies to which members had access. They also argued that at that time the number of papers submitted to the Association was insufficient to warrant two meetings per year. Not only had the increased number of specialties threatened the generalist nature of the Association, but also the growth in specialist societies meant that members were more likely to submit papers to those societies most relevant to their work. The problem for the Association hence remained twofold. The first was how to increase the representation of all areas of medicine with which different members were involved, and the second, how to do this in the face of the threat of other specialist societies. Specialization created the threat of fragmentation in the identity of the medical profession, especially among those who were involved in research. It was necessary for the Association to unite those working in different fields of medicine in order to maintain its position and status.

The question of whether or not to increase the size of the Association persisted, precisely because it seemed necessary to bring in more physicians from different fields. However, this presented problems: the more members that were admitted, the greater the number of papers that would be submitted for presentation at annual meetings and for publication in the *QJM*. In 1966, the secretary, G. de J. Lee,

presented information regarding the number of vacancies for membership occurring between 1936 and 1976, and compared these with the number of nominations received annually between 1963 and 1966. The data indicated that there would be few places for members in the next five years due to a small number of retirements, the result of changing demographic patterns. Progress was made when the Executive Committee unanimously agreed to an alteration in the Association's rules to increase the number of new members. In addition to Ordinary Members retiring to become Senior Members at the age of sixty-five (later lowered to sixty in 1970 to increase membership), a clause was added stating that retirement should take place before this if the member had retired from active practice. The Executive Committee was given permission to increase the number of Ordinary Members to a number not exceeding 375 over the next five years. These decisions were only made after a considerable amount of discussion and soul-searching. A letter from the Executive Committee to Newman in 1967 thanking him for his memorandum explained that it had:

unanimously agreed that the compact size of the Association should be preserved at all costs, and are fully agreed that the greatest discretion should be exercised in increasing the number of ordinary members from 350 up to the permitted ceiling of 375 members... In this way it is hoped that the Association will preserve its size at 350.¹²³

The fact that the size of the Association should remain small 'at all costs' demonstrates how the desire to maintain the exclusive nature, and so preserve the superior identity that members felt they had, meant that what was perhaps necessary change was not welcomed and as a result was slow to take place. In addition, there were practical restraints on the growth of the Association because at that time venues for the meetings were limited in size.

The Association was forced to change in other ways after 1945. For example, in 1945, it was decided that the number of Extra-Ordinary (or Senior) Members should be increased to allow for the number of men returning from war. More significant was the fact that the Association was never again to be an all-male group. Although a number of females, such as E.M. Widdowson, consultant at the Department of Medicine at the University of Cambridge, had previously given papers at meetings of the Association, in 1946 the first female member was accepted. Alice Stewart, of

the Nuffield Department of Clinical Medicine, Oxford, was involved in cutting-edge research on working conditions in factories and the connection between disease and industry.¹²⁴ At the general meeting in 1946, Stewart delivered two papers entitled 'Pneumoconiosis: a field study'. Her work was significant because it reflected a growing interest in social medicine and evidence-based medicine that was to characterize the post-war period.

In the context of the strong resistance to women in the medical profession, it is interesting that the Association invited Stewart to become a member. Despite women proving their ability during the First World War, many doctors opposed their entry into the medical profession. The reason for this opposition was complex. Already concerned about levels of competition in the profession, it was fear that the inclusion of medically qualified women would add to already fierce competition for house appointments.¹²⁵ At an institutional level, an influx of male students hardened by trench warfare after the war created difficulties in those institutions that had admitted female students as a wartime expedient. At St. Mary's this led to open hostility between male and female students within an emerging culture that favoured anti-intellectualism, team sports, duty, and loyalty, encouraged by an intractable misogynist attitude held by certain members of the teaching staff. Fears about institutional vitality were seen as more important than financial stability, and it was decided in 1924 to stop admitting female clinical students. Other schools were voicing similar concerns. Many feared that they would establish reputations as almost entirely female schools at a time when men in other spheres were attempting to 'reclaim territory' they felt they had lost to women during wartime.¹²⁶ Medical schools, especially those in London, remained unenthusiastic about admitting female students, and although women started doing the work of general practitioners and consultants during the Second World War hostility to them persisted. Most of this hostility tended to come from the rank-and-file of the profession and male students, rather than those at the top of the profession, whose positions were little affected by an influx of female doctors. An international survey of medical women in 1949 found that the most frequent career choices of women were paediatrics, psychiatry, obstetrics, gynaecology, public health, and general practice.¹²⁷ These were the areas of medicine that were practised by ordinary doctors, not by consultant physicians, and women did not seem a threat to those at the top of the profession. From the point of view of the Association, it was not necessarily an objection to women entering



Association of Physicians, Annual Dinner, Manchester, 1936, Courtesy of the Royal College of Physicians, 2434/286.

the Association that led to an all male membership before 1946, rather the lack of women who were able to attain high positions in medical research and teaching.

The papers that Stewart read at the meeting in 1946 show the innovative nature of her research into respiratory disease. In the first of these, she described the problems and methods of her attempts to study some of the social and economic consequences behind the high incidence of pneumoconiosis in colliers in South Wales. In the second paper, she gave details of the observations that she had made on 222 ex-coalminers who had been diagnosed with the disease. A willingness to accept females into membership of the Association, despite the on going opposition to women in medicine and the traditional nature of the Association, was shown when the President, Arthur W.M. Ellis, consultant physician at the London Hospital, congratulated Stewart 'on this happy inauguration of her membership'.¹²⁸ The Association welcomed Stewart because of the high quality of research, therefore placing the value of good research over the issue of gender. The acceptance of women into its structure was vital if the Association was to remain true to its aims of promoting unity among physicians.

However, it is important to remember that then there was little threat of women entering the Association and challenging its exclusively male-centred values. Stewart was nominated to join by those who already worked alongside her at Oxford. She was well known by her colleagues and would probably not have been asked to join had she not been the sort of person who would fit in with the Associations' values. Few women were in a position to follow. Only gradually did the number of female students rise in line with the number of women seeking places in medicine. Opportunities for female practitioners also remained limited. The limited number of female members of the Association before 1970 reflected this. Most were included following a growing trend to present multi-authored papers during this period, a trend that reflected the changing nature of university research departments. With more and more papers presented by two or more physicians, and with a growing number of these women, it allowed female members to be gradually integrated into the traditional male system rather than posing any social or professional challenge. None of these women held positions on the Executive Committee at the time. Whether this was deliberate exclusion is conjecture.

The changes in medical thinking and techniques, which were evident after 1945, had a fundamental impact on the content of the Association's meetings. The study of nutrition, which had gained in prominence during the inter-war period, now became a major focus in medical research. Social change necessitated this. Between 1860 and 1960, for example, increased food processing meant that the average consumption of sugar doubled, fat consumption rose by around forty per cent, and there was a ninety per cent decline in fibre in British diets.¹²⁹ Neuro-psychological disorders also came to the fore, partly as a result of wartime trauma experiences by soldiers. Such changes had a major impact on the research carried out by individual members of the Association. This was reflected in the discussions held at general meetings and in papers published in the *QJM*. The Association was also at the forefront of discussion of scientific advances such as radioimmunoassay and genetics in the late 1960s. A symposium entitled 'The contribution of genetics to clinical medicine', introduced by Cyril Astley Clarke, Consultant physician to the Royal Liverpool United Hospitals, for example, took place at the annual meeting in 1968 and considerable discussion of the relation of genetics to common diseases was had.¹³⁰ The continued rapid growth of specialist areas of medicine, such as neurology, meant that the Association faced the difficulty of covering a wide range of subject areas in the short time allowed at general meetings.

In order to address these difficulties, a new format for meetings was developed. In 1955, it was decided that the Association should have a symposium in London every five years to allow a deeper exploration of selected topics. The decision was based on what the Executive Committee thought would be of greatest interest to members, and that demonstrations of local work should be made at provincial meetings. In 1956, the first symposium was held on the subject of 'Population Studies as a Technique of Clinical Research'.¹³¹ Social medicine and evidence-based medicine were now at the forefront of much of the research that was being undertaken, as a result of the work of Archie Cochrane, a member of the Association, at the Welsh National School of Medicine. This reflected a shift in the emphasis in research from concern with the individual or with specific diseases to wider issues of population medicine. It was necessary for the Association to include members who were carrying out research in this important field. More than this, it marked a change in the ethos and direction of medical research. The aim of holding a symposium rather than a demonstration, as had previously

been the case, was 'to get a group of findings showing the sort of contributions to medical knowledge that may be made by physicians extending their work outside the far walls of hospitals'.¹³²

The scientific business of the Association began to reflect this shift to social medicine such as the effect of different occupations on health. A number of papers were presented along these lines; for example, Richard Doll (later Sir Richard) and Francis Avery Jones (later Sir Francis) introduced a paper in 1948, which described their 'Observations on the Occupational Incidence of Peptic Ulcer'. This was a major study of 6,047 men and women in different occupations that had been interviewed by the authors. They found that men between the ages of forty-eight and fifty-five years were most likely to suffer from peptic ulcer, and that an excess was found among men holding responsible positions in industry, among executives, and among firemen.¹³³ Similarly, in 1949, Donald Hunter, consultant at the Royal London and later President of the Association, read a paper on 'Some New Toxic Hazards of Industry'.¹³⁴ These papers produced a considerable amount of discussion, and it is evident that they reflected areas of great interest to members than the more specialist papers did.¹³⁵

The growth of evidence-based medicine was symbolic of a trend that saw traditional clinical medicine pushed further to the sidelines. During a discussion on the future of the Association in 1950, Witts, one of the older members, reminded the Executive Committee that during the forty-three years since the Association was founded there had been 'great changes in society and medicine'. He referred to the multiplication of specialties and the great enlargement of numbers of consultants, teachers, and researchers in internal medicine. The foundation of the NHS added to the complexity of these changes: it created new systems of funding that affected research and the hospital system. The development of specialist societies, 'which were now so numerous that there seemed no organ of the body without its own society', raised serious questions about the best way for the Association to recruit the best men and the best papers. How the Association was to continue to be regarded by younger men, as they described it, as the 'blue-ribbon' of internal medicine in Britain was a major problem that needed addressing. It was feared that these younger men might deem the Association irrelevant or old-fashioned.

Many members remained committed to the Association's traditional generalist values. They were reluctant to accept major alterations to the Association's constitution, fearing that this may result in a loss of status. For example, the

dinners and networking remained a fundamental incentive for membership. Throughout these years, the Association managed to maintain its reputation and standing. Papers never ceased to represent cutting-edge medical research. Members felt that 'there was a kind of paper that belonged properly to the Association, in distinction from the research communications and specialist topics which were appropriate to other societies'.¹³⁶ Physicians who belonged to the Association continued to value its generalist approach in spite of the developing subject nature of papers given. Above all else, in a profession that was rapidly expanding and becoming increasingly diversified, the Association continued to uphold traditional values and offer members a sense of belonging to a unified and esteemed professional group.

The *QJM* and the nature of the Association: 1970–1985

The standard of papers read and those published in the *QJM* continued to be considered by many physicians to represent the cutting edge of scientific medicine. Without the discussion of matters of interest to consultant physicians, the Association would not have continued to attract those deemed to be at the top of their profession. This was important for members because it was a fundamental part of retaining respect, influence and status. However, although the standard of scientific papers remained high, by the 1970s it had become increasingly difficult to include a large number of papers of general and specialist interest in either the annual meetings or the *QJM*. If the generalist perspective of the *QJM* was a crucial part of its identity, it became evident that it was only in the acceptance of specialization that the Association could continue to play to its strengths—the bringing together of physicians in order to promote networking, to advance individual careers, and the promotion of internal medicine. In order to retain the identity of scientific excellence, changes in the scientific content of meetings and of the *QJM* were needed.

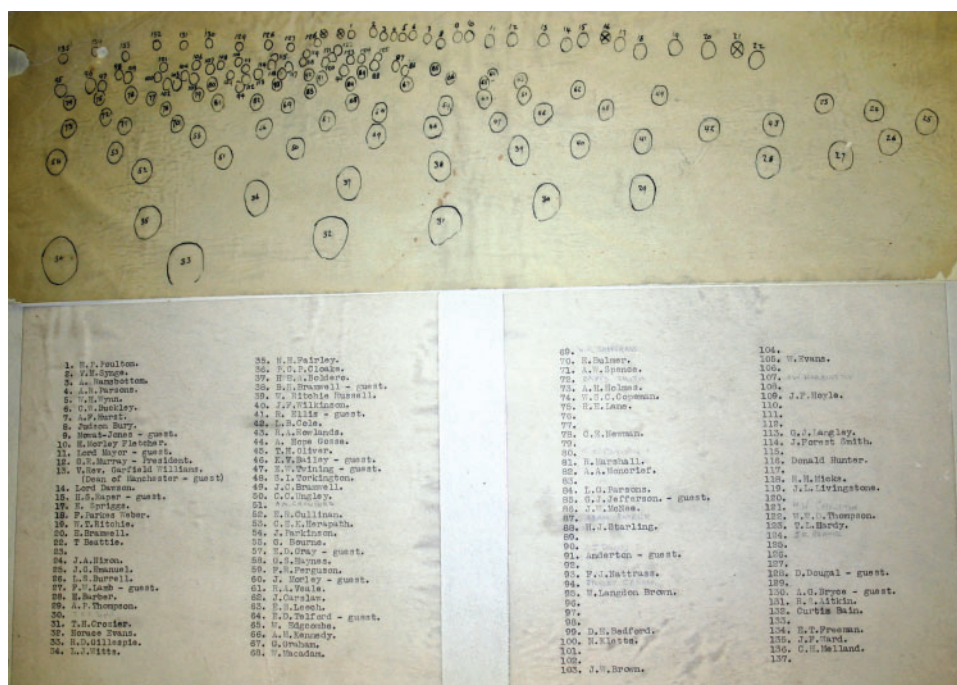
To meet this problem, the Executive Committee actively encouraged the submission of papers from across the board. In 1972, for example, Douglas Black (later Sir Douglas), Professor of Medicine at the University of Manchester and the senior editor of the *QJM*, appealed to members to submit more papers for publication.¹³⁷ In 1971, the idea of holding a symposium on a specialist subject was experimented with.¹³⁸ The symposium was not a success, largely because it did not appeal to those

who were not involved in that area of research. For those who were interested, busy schedules and other commitments prevailed. At the meeting of the Executive Committee a year later, a short discussion of the question of holding further meetings was had but no definite decision was reached. No further additional meetings were planned. It seems that members felt that there was little incentive to attend such highly specialized meetings, which lacked the social or professional benefits of the annual get together. Specialist meetings that interested only a fraction of the members removed the element of general medicine and networking that remained the essence of the Association.¹³⁹

However, the need to accept specialization was essential if the Association was to maintain its scientific status and reputation. In 1971, only seven or eight subject areas were covered, and important specialist fields, such as cardiology, endocrinology and gastroenterology, were addressed in more than one paper. Some areas, such as neurology, were not discussed, presumably because no papers were submitted or were considered to be of a good enough standard.¹⁴⁰ The ideal was that no more than one paper should be read on any specialist field. By 1975, more specialist areas were being acknowledged at the annual meetings, a move that reflected the growing trend in medical research. As well as those mentioned above, papers on infectious disease (*Hepatitis B virus infection in the initiation of, and K cell cytotoxicity in, active chronic hepatitis*), chest medicine (*Radiology for Advanced Emphysema*), and renal medicine (*Neoplastic disease and the nephrotic syndrome*) were read.¹⁴¹

Changes in the format and style of the *QJM* also took place in these years. When D.H. Brinton, neurologist at St Mary's Hospital, who had been editor of the journal since 1954, retired in 1969, the number of subscriptions to the *QJM* and the quantity of papers submitted for publication was falling at a steady pace. From 1970, the Senior Editor, John Nabarro (later Sir John), of the Middlesex Hospital Hospital, introduced changes in the format of the journal following the recommendations of the Executive Committee. The circulation of the journal, which stood at approximately 3,000 at this time, was considered to be far 'too low'.¹⁴²

Like most proposed changes within the Association, solutions were difficult to find and slow to be implemented. This was partly due to the formalities of proposing and introducing change via the Executive Committee, which was a long and slow process. It was also a result of the attitudes of those involved. In 1972, the only change that had



Association of Physicians, Seating plan for the Annual Dinner, Manchester, 1936, Courtesy of the Royal College of Physicians, 2434/287.

been made was to increase the annual cost of the *QJM* for non-members from £3.75 to £5 and, in an attempt to improve the content and variety of papers published, a request was made to members for more papers. Improvements were hampered by frequent changes in officers of the *QJM*. In 1972, for example, only two years after the retirement of Brinton, the senior editorship was passed on to Black.¹⁴³ The voluntary nature of the role meant that those on the editorial board were likely to leave after a short period as a result of work pressures or changes in situation. Similarly, in 1973, J. Leonard-Jones, consultant in gastroenterology at St Mark's Hospital, London, felt it necessary to retire from the editorial board after only two years in office.¹⁴⁴ While in theory frequent staff changes helped the input of fresh ideas, in reality any progress that had been made was hampered by a lack of continuity. This was a problem, because the *QJM* was not only an important part of the Association, but also the Association's major source of income. The journal needed to flourish for the Association to survive.

Although the affairs of the *QJM* were considered satisfactory, the need for change was recognized by editorial staff and by members of the Association who had close interests in the journal's performance. Positive developments did occur. The editorial board and editors worked to strengthen the journal's international links. This was something that was fundamental in fulfilling the aim of the

Association by promoting internal medicine and the excellence abroad as well as in Britain.¹⁴⁵

However, by 1980 the *QJM* still faced the threat of falling subscriptions: the number had fallen to 2,928 in 1979 and in 1980 to 2,827, mainly as a result of competition from other medical journals and increasing costs. Although the *QJM* was not doing less well than other medical journals, members were warned that it was 'important not to be complacent and to attempt to make the journal more attractive in a highly competitive market'. Philip Hugh-Jones, the senior editor and Professor at the Royal Postgraduate Medical School, at this time, considered the unique selling point of the journal should be to remain 'as a prestigious journal of original contributions to medicine'. The *QJM* was to succeed by focusing on the importance of science, just as the Association did.¹⁴⁶

Nevertheless, change was necessary in order to keep up with the development of other medical journals and the growing market of medical literature. It was hoped that new ideas would go some way to quietening the dissatisfaction that was being voiced within the Association about the performance of the *QJM*. Criticisms from members, such as O.M. Wrong at the University of Manchester, emphasized the poor performance of the journal in comparison with others like the *Annals of Internal Medicine*, which had a circulation of 76,000, or *Medicine* (a journal more on the level of *QJM*), which had a circulation of 8,500.¹⁴⁷

It was the progressive ideas of individuals that finally pulled the journal into the modern phase of its history. Hugh-Jones invited new kinds of articles, such as those on the 'State of the Art', which 'might be attractive in order to present specialist subjects of leading interest to practising physicians in other fields'. He also encouraged the introduction of an advertising stand to promote the journal at different scientific and medical meetings. In discussion, Walter Somerville, at the Institute of Cardiology London, suggested that the Oxford University Press be encouraged to promote the journal at clinical meetings in the United States as well as Great Britain and Ireland. This demonstrates a definite move towards making the journal more acceptable to a wider international audience, especially an American one. It reflected the importance felt by members of the need for networking on an international scale and their recognition of where major advances in medicine were now being made. Further ideas, such as appointing an Editor-in-Chief, and reconstituting the traditional Editorial Board were considered.¹⁴⁸ Professor Franklin Epstein of the University of Harvard was invited as the first American physician to join the Editorial Board. This was a way of raising the international awareness of the Association. A specialist working party was set up to discuss these ideas 'so that implementation of them need not be delayed until the next AGM'.¹⁴⁹

By 1983, several of the suggested changes had been implemented, including the introduction of peer review, an enlarged editorial board, and the institution of review articles. These changes reflected wider trends in the style of other medical journals and the need felt by the Association to maintain the reputation of excellence that the *QJM* had built up. The question of whether or not to publish the journal monthly was now under discussion, and even at this early stage, it was generally felt to be a desirable move.¹⁵⁰ Much of the credit for the streamlining of operations regarding the journal must go to J.M. Holt, from the Nuffield Department of Medicine, Radcliffe Infirmary, Oxford whose hard work was noted by Hugh-Jones in his annual review in 1984.¹⁵¹ The importance of individuals such as Holt in the progress of the journal cannot be underestimated. Neither can the willingness of members to accept change. A postal ballot in the same year had revealed that a majority of 212 members were in favour of changing to a monthly journal while 191 were against. Fifteen members had abstained. The numbers were close but overall it demonstrated a readiness to accept change, which perhaps would not have existed previously. As a result,

the first monthly publications of the *QJM* were produced in 1985.

By the 1980s, the pace of advance and the high profile that medicine had achieved reassured members of the need for the Association. It was able to maintain its reputation of excellence through the continued discussion of new research and the maintenance of networking opportunities provided by the annual dinner. The acceptance of change within the Association was vital for its future, and for the future of the *QJM*, and it demonstrates the certainty of professional identity and status that members felt. Modifications to the running of the *QJM* and the Association were no longer viewed as so potentially damaging to their status.

Reforming the Association, 1986–2006

Although the Association continued to lead scientific discussion in areas such as the advent of the 'new genetics', it remained slower in implementing changes in its format and traditions of dinners, membership and numbers. Members, for example, continued to be chosen through a system of nomination by existing members and the final decision of the Executive Committee, based on merit and the delivery of papers at annual meetings. This meant that only those who were already well known and friendly with existing members would be nominated. Unlike the *QJM*, which had the Oxford University Press and the need to improve sales to encourage change, within the Association alterations could only happen under the leadership of progressive individuals. Nevertheless, over the past fifteen to twenty years, the action of a number of forward-thinking Presidents, Secretaries, Treasurers and members of the Executive Committee has led to significant changes in the Association. For example, in 1986, A. Hollman suggested that a more democratic voting system might be used for elections to the Executive Committee. Rule 16 was amended to read that a list of candidates proposed for election to the Committee should be circulated one week before the AGM where the members would then be elected.¹⁵² Similarly, under the presidency of Sir David Weatherall a review of the format of the AGMs and election to membership was set up in 1990. While he strongly supported the view that the Association was 'an important and prestigious Association', Weatherall also wondered whether it might not be possible to increase membership beyond 350 Ordinary Members.¹⁵³ After investigating the number of people that medical schools where meetings might be held

could accommodate, it was concluded that membership should be raised from 350 to 375 over the next five years, 'a pace of change with which the Association could cope' Weatherall wryly observed.¹⁵⁴

An important development, introduced in 1988, was the 'Links with Developing Countries' scheme. This was a charitable initiative suggested and pushed for by Eldred Parry, Professor of Medicine at the London School of Tropical Medicine. This initiative demonstrates a genuine desire on the part of the Association to encourage the development of medicine and research on an international level and was a recognition of the important role that the Association could play in fostering these things. A committee chaired by Steve Tomlinson, Secretary at the time (and later Treasurer and President) was established which persuaded the Executive Committee to set aside £20,000 per annum to award to members to establish educational or research links with a developing country. The link would involve the exchange of personnel so that a member would visit a particular country and identify somebody to visit Britain for between one and three months for training. They would then return to their country and train fellow healthcare professionals. In the first year, four projects of £5,000 each were awarded for Tanzania, Zimbabwe, Ethiopia and Kenya. During the second year, links were also formed with India, Malta and Nigeria, as well as a second one with Tanzania.¹⁵⁵ For the Association this was a progressive initiative, one that was well received and supported by members. The original countries that were considered to be eligible for the scheme were those in South America, South East Asia and Africa, but by 1991 it had become obvious that with the evolving situation in Eastern Europe the time had come to include these countries in the scheme.¹⁵⁶ In the same year, an informal association with the Tropical Health and Education Trust established in 1988 by Parry was made, and this proved very helpful in promoting and establishing links.¹⁵⁷ By the end of the 1990s, successful links had been established with Uganda, the Baltic States, South Africa, Burma, China and Bangladesh, and the idea of awarding a reduced number of larger awards was welcomed. In 1999, when Tony Weetman was Secretary, the scheme was modified to allow two awards of up to £10,000 per annum to allow substantial projects to be undertaken, with £5,000 set aside for pilot schemes.¹⁵⁸ Although the popularity of the scheme had peaked, overall much good was achieved through the spread of knowledge and the number of applications remained high. In 2001, for example, seventeen 'high quality' applications were received.

Another important charitable initiative, the awarding of studentships, was introduced in these years. When Steve Tomlinson took over from Peter Watkins as Treasurer (having been Secretary of the Association from 1988) in 1994, he suggested that 'even if the full allocation of £20,000 per annum were to be spent on links with developing countries, the Association could still afford to spend an additional £20,000 each year'. Suggestions were put forward about what to do with this money. Tomlinson's proposal that studentships, to be known as 'Association of Physicians of Great Britain and Ireland Studentship awards' was accepted. £30,000 per annum was therefore put aside for the scheme, which was aimed at medical students taking an intercalated degree following a decision by the MRC to longer fund these degrees. It was agreed that £5,000 would be made available to each of six medical schools on a rotational basis, and that money would be used to support up to three students per school to pay for fees or maintenance during tenure of their intercalating year. It was planned that a cycle of the medical schools would be completed in alphabetical order by the year 2000.¹⁵⁹

The first schools to receive these awards in 1995 were therefore Aberdeen, Belfast, Birmingham, Bristol, Cambridge, and Cardiff, while in 1996, Charing Cross, Cork, Dublin, Dundee, Edinburgh, and Glasgow received awards.¹⁶⁰ This programme proved to be an even greater success than the 'Links with Developing Countries' scheme. In 1999, it was agreed that seven studentship awards (now known as B.Sci.Med Studentships) would be made each year.¹⁶¹ In the same year, Tony Weetman, who succeeded Tomlinson first as Secretary and then as Treasurer, proposed that the Association should also offer undergraduate studentships, which would give £600 per medical school each year for three years for research electives.¹⁶²

These initiatives reflected the progress the Association was able to achieve in the 1990s from a combination of members with new ideas and an Executive Committee that was willing to accept change. The Association had entered a phase of renewal and the enthusiastic development of charitable giving, which aimed at promoting internal medicine among students and in developing countries. In doing so, the Association managed to foster a new and relevant role for itself in promoting medical development.

Other changes took place in the 1980s and 1990s. Although they were smaller in scale, they were equally indicative of a perceived need for



New Hunt's House, Guy's Campus London, setting for the 100th meeting of the Association of Physicians.

changes in old customs. For example, there had been a custom whereby the Secretary was required to know all the members, and when a member asked a question following a paper, the Secretary had to write the name of the questioner on the board. As Weetman explained,

Such prodigious feats of memory were beyond me, and when Steve Tomlinson invited me to become Secretary it was on condition that this custom was dropped. With over 400 members, as well as a large number of Senior Members, I think it would be difficult for any Secretary to do this now, and of course the custom could lead to embarrassing situations when a senior member of the profession was not identified.¹⁶³

For Weetman, the practice was 'distracting for members of the audience, at least some of whom...were anticipating secretarial amnesia'.¹⁶⁴ It was abandoned in 1993. Weetman also encouraged changes to how papers were selected. While secretary, he introduced a scoring system which tried 'to take account of the need of the Association to have a good balance of specialist and geographical spread' and which reduced the amount of

discussion previously required over papers on the part of the Executive Committee.¹⁶⁵ Similarly, Tomlinson and Weetman changed the format of the annual meetings. Instead of beginning on a Thursday evening as they had previously, they began on a Thursday afternoon with the AGM and ended on Friday evening with the dinner. This suggestion was carried by 13:1, with the proviso that the format be reviewed again two years later.¹⁶⁶ More significantly, fears among members that the Association was not offering fair criteria for the selection of members led to discussions about the best way to widen applications for membership. In 1995 it was agreed that abstracts for forthcoming meetings and applications for membership would both be assessed using a scoring system. It was the work of individuals serving on the Executive Committee who pushed forward ideas for reform that allowed these minor but necessary changes to eventually occur.

The scientific business discussed at annual meetings, although criticized by some members for being too focused on particular areas of medicine, such as molecular biology or immunology, continued to represent advances at the forefront of scientific research. Throughout the 1980s and 1990s, the increased understanding of immunology, infection

and inflammation was reflected in the minutes of annual meetings.¹⁶⁷ In the 1990s, the development of new imaging techniques, including CT scans, ultrasound and MRI, became popular subjects for discussion at a time when these represented exciting new developments in medicine. Nevertheless, in addition to focusing on science, attempts were made to broaden the research presented. Whereas the Association had made a necessary move to embrace more specialist areas in the hope of attracting leading physicians, a growing recognition of the values of generalist medicine to members, for reasons of interest and status, started to necessitate a move back to the original aims of Osler and the founders. This was not to maintain the *status quo* of medical practice but to preserve the interest of leading physicians.

The *QJM* continued to expand in this period. Despite the continuing fall in library subscriptions and the volatile nature of the journal market, the development of overseas links, changes in format, and online subscription did much for the profile of the journal. By 1986, some twelve to thirteen per cent of submitted papers were coming from overseas. This confirmed that the journal was fulfilling the aim of promoting medicine on an international level, which was perhaps where the Association now saw more of a need. After one full year of being published on a monthly basis, the number of papers submitted had doubled and almost half of those were accepted. The content was also being extended, with the introduction of review articles and editorials.¹⁶⁸ In 1992, a new editorial board was appointed and expanded to thirty-three members with a strong cover across the clinical subspecialties as well as in the 'new' molecular sciences, something which had been called for a number of years.¹⁶⁹ A mini-review series was introduced in 1993, which gave 'pithy accounts of well defined topics' and specifically aimed to bridge the gap between cell and molecular science and clinical medicine'.¹⁷⁰ Advertising became an important issue and vigorous efforts were made to promote the journal in Eastern and Central Europe and the Far East, as well as the USA.¹⁷¹

However, the single most significant change in this period was the publication of the journal online in 1998. Under Julian Hopkin as Executive Editor, Ovid Publishing published the *QJM* in full text form on the Oxford University Press website and as part of an electronic medical science package. This naturally made the *QJM* more readily available for non-members and increased its international reach. In the early twenty-first century, the impact of the *QJM* grew as a direct result of this development and the number of institutions subscribing to the

online journal increased, although the number of private subscriptions remained small. In many ways, the *QJM* was forced to modernize as a result of advances in technology and changes in publishing. More change occurred in both the *QJM* and the Association in the 1980s and 1990s than in the rest of its history.

Conclusions

The Association of Physicians of Great Britain and Ireland was founded in a period of change and instability in medicine. Increasing specialization and fears that Britain was being left behind on the international stage contributed to the need for an Association. Those working in the London teaching hospitals felt the need for unity amongst consultant physicians and for the maintenance of their status and power at a time when this was being challenged. The Association was founded as a response to the fears and ambitions of these men. The original aims—to promote internal medicine and friendship among physicians—were the direct result of the need felt to encourage the development of a new elite through the discussion of the latest developments in medicine, and by bringing together those who were deemed to be at the top of their profession.

In the decades that followed, the Association played a vital role in maintaining an identity for members and unifying them as a professional group. Moreover, the invitation of new members demonstrates the important professional networks that the Association used and developed to further this identity. Those who were invited to join from universities and hospitals outside London became closely linked with physicians working in the London teaching hospitals and the strong provincial teaching centres in the British Isles, and through these links began to identify with, share and uphold, the traditional values associated with the major teaching hospitals. The ongoing focus of the Association on clinical rather than laboratory-based medicine was a way of maintaining the traditional values of medicine, which were so important to these physicians. However, this was not at the expense of laboratory-based medicine. The Association provided a conduit that brought 'science' and clinical medicine together in a practical way that found favour with physicians. The annual meetings offered a forum for discussion that allowed those who were otherwise isolated in their institutions to share their observations with others and for the verification or adaptation of findings.

Throughout the inter- and post-war eras, the nature and practice of medicine continued to change, and the papers presented at the Association reflected these developments in medicine and research. Perhaps more important was the continuing role that the Association played in maintaining the identity of members in the face of growing specialization. The Association remained unique in its promotion of a general knowledge of medicine among physicians. Members accepted the specialization of research (and most belonged to specialist societies) but many also valued the identity of scientific excellence combined with a general knowledge of medicine that the Association provided. The struggles that the Association faced with the slow but necessary reformation of its workings resulted from fears that alterations that allowed for the changes in medicine would also lead to a loss of identity for the Association and those that belonged to it. It was felt that it should continue to uphold the values with which it started, and this included its general medical stance and exclusive membership.

In the last twenty years, change in the Association has been implemented with less resistance and with greater enthusiasm. The impact of particular progressive individuals, including the present Secretary, John Iredale, and Treasurer, John Connell, on the history of the Association has resulted in a number of reforms to the traditional features of meetings, and to its charitable impact on a national and international scale. Such individuals saw avenues that the Association could follow in order to retain a significant role. The continued success of the *QJM* under the editorships of Julian Hopkin and Christopher Martyn has meant that the Association has been able to fund these charitable ventures, including providing stipends for intercalating medical students undertaking BScs. Of particular note, the 'Links with Developing Countries Scheme' has provided extremely valuable funding for research based in the developing world, and the 100th meeting in 2006 saw Fasil Tekola travel from Ethiopia to make the first poster presentation delivered by a researcher funded through this scheme. Questions have been raised about the reasons for these changes. It seems reasonable to suggest that they reflect the academic professional security and self-esteem now felt by those working and researching in teaching hospitals and universities across the UK and Ireland. As members' positions have become increasingly recognized, there is no longer the threat of a loss of identity, power and status, and resistance to change has thereby decreased.

Membership of the Association is as strong and diverse as ever. In 2003, the President, David Barker, welcomed twenty-three new members, and at the 100th Meeting in 2006, Robert Lechler welcomed a further seventeen. Throughout recent years, new members have included men and women from across Britain and Ireland. The Association's appeal remains the standard of the papers delivered at annual meetings, its exclusive nature, and the importance of networking between old members and new. John Reid, President 1996–1997, recently said that although no particular occasions or events stood out in his memory, 'the Association has provided an opportunity for enjoyable reunions with old friends, [an] opportunity to extend relations to new friends and colleagues and to network'. The Association's value outside of these matters is no longer as clearly defined as it once was. The push for change and the development of charitable schemes is perhaps a reflection of the need for the Association to remain relevant to the profession and medicine as a whole. Meanwhile, the old problem of how to include all specialties within meetings and still keep them of general interest remains. In the years to come it will be interesting to see how the role of the Association develops, and how the general interest of annual meetings will be maintained.

There are many reasons to be optimistic about the future of the Association. Despite outward appearances of conservatism, the identity of the Association, has not remained static; rather, it has evolved over a century that has seen extraordinary changes in the science and practice of medicine. The Association has developed a culture that facilitates the exchange of cutting-edge ideas, technology and best practice in all aspects of clinical science and medicine. This culture largely results from the membership selection process, which places a premium on research excellence. As medicine continues to change, the need for a forum for academic exchange across specialties has not diminished; arguably, it has increased. Given the success of the Association over the last 100 years, there is every reason to suppose that the next 100 will see the sustained growth of a dynamic and vigorous organization that brings together the best in British and Irish clinical science and medicine.

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