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# Pharmacists and medical doctors in nineteenth-century Belgium

**Abstract** In this article the main areas of conflict between the medical and the pharmaceutical professions in Belgium in the 19th century are outlined. The medical profession was dominant in the division of labour and the pharmacists were not allowed to threaten its position. However, pharmacists were also able to achieve their objectives – geographical expansion of their officially recognized monopoly and the safeguarding of the pharmacist's key role in the dispensing of drugs, including proprietary drugs. They also managed to push the less qualified druggists out of the officially recognized division of labour in medicine.

## Introduction

The object of this paper is to document the evolution of the relationship between medicine and pharmacy in Belgium in the 19th century. The first section gives a brief review of the relevant characteristics of the division of labour between medicine and pharmacy in the Ancien Régime, during the French Revolution, and under the Dutch Government. In the second section, developments in education and in the structural position of the two professions in the 19th century are discussed. Attention will be given in particular to problems associated with the demarcation of their respective fields of activity, such as dispensing by medical practitioners, the issue of proprietary drugs, and the pharmacists' struggle against the druggists – wholesalers of crude drugs and chemicals. The physicians were dominant and were successful in protecting their professional territory. The pharmacists, however, were not powerless. They developed a separate professional identity and were able to establish and maintain barriers around their professional domain and to protect it from encroachment by

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druggists and ultimately from physicians as well. Finally, some comments are offered about the professional dominance of doctors[1] and historical variations in the division of responsibilities between the professions.

## Medicine and pharmacy before Belgian independence (1830)

The principles guiding the practice of medicine promulgated by Emperor Charles V on 8 October 1540 can be considered as the first of a series of legal moves to try to create a coherent division of labour in medicine, bound together by a unified system of licensing and discipline.[2] *The doctors and licenciates in medicine* were authorized to practice internal medicine throughout the country. Strictly speaking, this was limited to advising and prescribing. It was the *apothecaries'* task to compound and sell drugs and other substances used in the practice of medicine, and to ensure the quality of the drugs. Apothecaries were legally prohibited from prescribing drugs or diagnosing illnesses, i.e. from encroaching on the physicians' professional territory. The practice of *surgery* consisted in the treatment of all external disease and in the use of surgical instruments.[3]

Licenses to practise were granted by the *collegia medica*.[4] The two oldest colleges, in Antwerp (1620) and Brussels (1650), were at first exclusively composed of university-trained physicians. But, by the eighteenth century, however, there is little evidence that physicians dominated the colleges. The *collegia medica* established lists of registered practitioners and apprentices, supervised medical practice and disciplined offenders. They were also responsible for public health measures and organized medical care for the poor. Apothecaries and surgeons also had their own guilds, i.e. the wealthy grocers' or mercers' company and the surgeons-barbers' guild.

However, *collegia medica* were only established in nine Belgian towns. In the smaller towns and rural areas, the attempts of the state and the town authorities to distinguish between different types of practitioners probably had less impact. For example, both physicians and surgeons traditionally dispensed medicines when there was no apothecary in the vicinity. This was the case in large parts of the countryside, for the majority of the apothecaries practised in towns. Around 1750, 95% of the apothecaries in the Duchy of Brabant had their shop in a town (Bruneel 1977: 180). The rural surgeons, who

were the most important practitioners in the countryside, combined the work of the various branches of medicine, including pharmacy. Some also engaged in non-medical activities to supplement their meagre incomes.

There was not only a distinction between the urban and rural division of labour but also in the urban setting between the formal demarcation of professional activities and what was actually done in practice. In theory, the physicians held a dominant position over other medical practitioners. Through the *collegia medica*, they could interfere in the admission to and the practice of the other branches of the art of medicine. In the case of pharmacy, for example, they supervised the quality of the pharmaceutical preparations, inspected the apothecaries' shops together with officers of the apothecaries' company, and compiled a pharmacopoeia. A medical prescription was needed for the sale of compounded drugs and for bleeding and purging. The physician had the right to supervise difficult surgical and obstetrical operations. Physicians claimed superiority and higher status because of the pre-eminence of medical diagnosis and prescription in the treatment process and because of their university education, which covered not only medicine as such but also pharmacy, chemistry and anatomy, the core disciplines of the two other groups. They were inclined to disparage the competence of the other medical practitioners, who were not university-trained. For example, in the case of pharmacy, they emphasized the practical, craft-like character of the pharmacists' work – they saw them as only cooks and preparers with little knowledge to assess the medical qualities of the drugs – and they disdained their mercantile activities. But in practice, the civil authorities, apothecaries, surgeons and clients were not at all eager to recognize the dominance of the physicians. Apothecaries, in particular, were very critical of the physicians' claim to superiority. The latter were not always in a position to enforce the dominant position to which they considered they were entitled, because the economic base of the apothecaries was stronger. It could be that the apothecaries' origins in a trading company marked them as men of inferior status to physicians, but their affiliation with the grocers' company enabled them to establish independence and freedom of operation. Hence, formally the medical profession may have been more dominant than they really were in practice.

The core issue of debate and conflict between apothecaries and physicians was the degree to which doctors should control medicines, and hence pharmacy, through prescription. The physicians insisted

that apothecaries should dispense compounded drugs only on medical prescription. Apothecaries on the contrary argued that an obligatory prescription would put an unnecessary financial burden on the public. At least in Brussels, where the conflict paralysed the functioning of the *collegium medicum* for some time, it became accepted that pharmacists had the right to visit patients once or twice and to give them ordinary drugs without a medical prescription (Broeckx 1862: 193).

The subsequent changes in the political regime during the French and Dutch periods made this basic pattern of incomplete division of labour in the major towns, and combination of the various branches of medicine in the smaller towns and the countryside, more uniform and explicit. They did not alter it, however.

The French law of 1803 on the practice of medicine[5] created a new class of medical practitioners, the health officers, to deal with the medical problems of the poor in towns and rural areas. Health officers, who were in fact the successors to the rural surgeons, as well as doctors could dispense drugs if there was no apothecary in the vicinity. The rationale was that any person receiving medical care should be able to obtain proper and sufficient drugs and medicines. More or less the same considerations played a role when a government commission was charged in 1815 with the harmonization of the medical legislation between the Northern and the Southern Netherlands.[6] Although in favour of a clear separation between medicine and pharmacy, the commissioners made allowances for the special conditions of the rural areas and the smaller towns, where not only the survival of a practice depended on the ability to dispense but where also poverty and long distances made combination more or less inevitable for the provision of adequate medical care. Therefore, combination of medicine and pharmacy was allowed in rural areas and in towns without a local medical board. These boards could be formed only in towns with at least four doctors in medicine or in surgery, but their establishment was never obligatory. The initiative was left to the local authorities, who were also responsible for their financing.[7] In practice, this provision led to combination being permitted everywhere except in the larger cities.

In summary, the legal and normative barriers between the physicians' and the apothecaries' tasks were only in force in the larger cities. Particularly in rural areas, physicians as well as surgeons practiced dispensing as well as prescribing. Secondly, the physicians and the apothecaries were concerned with maintaining

their legal privileges and monopolies and with attempting to limit the other's territory as much as possible. In contrast to the situation in Britain, Belgian apothecaries never gained a legal right to prescribe and to practise medicine although some involvement in medical matters seems to have been allowed by town authorities.

## Medicine and pharmacy in the 19th century

The medical profession remained dominant in the 19th century. Leading pharmacists pushed for a status equivalent to that of the doctors in terms of education and representation in policy-making bodies but most of all they sought to secure the pharmacists' monopoly in the compounding and dispensing of drugs throughout the country. In other words, what was really at stake in the often heated debates between pharmacists and physicians was the extension of the division of labour, that had already been established in the major towns, to the smaller towns and the rural areas. A second, related problem, especially at the end of the 19th century, was to incorporate a new type of product, i.e. the proprietary drugs, in the division of labour. A third issue, which will be discussed briefly, was the relationship between pharmacists and druggists.

*Educational developments.* Pharmacists made great efforts to introduce stricter rules for entry to their profession and to improve its educational standing. They were in favour of a common basic scientific training for pharmacists and physicians. Indeed, was pharmacy not as scientific as medicine? They argued:

> Si le pharmacien vend, c'est surtout sa science et il le vend comme le médecin la sienne. S'il exécute, il ne fait que mettre en pratique ce que la théorie lui a enseigné, de même que le chirurgien exécute dans ses opérations ce que la science lui a appris (BARM 1842: 385).

They also worked for the re-introduction of the title of doctor of pharmacy[8] and for higher entrance fees. Both were considered as means of recruiting candidates from higher social classes and of enhancing the prestige of the profession. Moreover, the doctor's title could promote the scientific progress of pharmacy by making the field more interesting to students who wished to follow a research career. Furthermore, they argued for examination juries composed mainly of pharmacists and for the abrogation of existing

territorial constraints, which were only applicable to the lower grade medical practitioners.

Pharmacists received the qualified support of the physicians for their struggle. A low educational standing in pharmacy not only threatened the quality of the drugs dispensed but also led to overcrowding of the pharmaceutical profession and this meant competition, lower standards, secret remedies and, what was critical in the eyes of the physicians, encroachment into medical matters. But a high educational standing was no less menacing. When in 1842 the Royal Academy of Medicine discussed a draft bill which brought pharmacists during the first two years of training to the same level as the medical doctors (degree of bachelor of science), they decided not to back it. A new government proposal in 1849 that made the pharmaceutical training considerably less demanding was welcomed by the physicians. According to the chairman of the Academy, students with a bachelor's degree in science would be inclined to study medicine instead of pharmacy, because medicine was more prestigious. This would lead to overcrowding of the medical profession and to a shortage of pharmacists. Moreover, there was no reason to make the pharmacists' training so difficult except for the desire to limit their number. He added:

> Nous comprenons parfaitement ces exigences de la part de ceux qui veulent en quelque sorte monopoliser l'exercice entre les mains des pharmaciens actuels et dont près que pas un n'a passé à travers les dures épreuves qu'on cherche à imposer aux futurs aspirants. . . . La pharmacie se meurt, les pharmaciens meurent de faim; faites les vivre et pour les faire vivre, rendez l'accès à la profession plus difficile (BARM 1849: 585).

Of course, this statement did little to promote conciliation but a compromise was finally reached. It consisted of an introductory test for admission to the university, an examination for the degree of Bachelor of Pharmacy, two years of apprenticeship, a practical test, and an examination for the degree of pharmacist. For this last examination, a special jury would be appointed by the government. A doctoral degree was not planned, but the title of pharmacist would give the same prerogatives, i.e. they would be eligible to teach in a university. The examination fees were raised. These recommendations became law on 15 July 1849. The same law introduced the degree of Doctor of Medicine, Surgery, and Obstetrics and was the last important step in the process of the legal unification of the Belgian medical profession. Non-university

education in medicine was abrogated earlier by the Law of 27 September 1835 (Schepers 1985: 332). Although welcoming the fact that pharmacy gained university status, the leading pharmacists repeated their complaints about the low standing of pharmaceutical training, about the unequal treatment of the students in pharmacy whose entrance examinations to the university were easier than those of the other students and who did not receive any scholarship or grants, and about abuses in the apprenticeship period.

Towards the end of the century, the pharmacists' training became more difficult and more scientific. This was felt as a threat by the medical doctors who feared an increase in the number of medical students at a time when overcrowding had already led to competition and low fees and jeopardised the realisation of greater uniformity and harmony within the medical profession. it was said:

> L'effet de cette loi (1890) sera de rendre l'accès de la médicine plus facile et plus difficile celui de la pharmacie, de dégager ainsi cette dernière profession au détriment de la nôtre où l'encombrement prendra de plus en plus des proportions désastreuses.[9]

This would lead to a vicious circle: the low status and income of the medical profession would discourage ambitious and competent young men from studying medicine. Moreover, a weakened profession would no longer be able to oppose the pharmacists' objection to the combination of medical and pharmaceutical practice – in Belgium also referred to as the medical-pharmaceutical cumulation – and their demands for better protection of their professional territory and higher income.

*The structural position of the pharmaceutical profession.* At the university, the pharmacists belonged to the medical faculty, and the medical doctors interfered with their teaching. Hence to a certain extent, the terms of entry remained controlled by physicians, although this gradually changed towards the end of the century.

The most important policy-making bodies after Belgian independence (1830) were the Belgian Royal Academy of Medicine (1841) and the provincial medical boards. The Academy's role was to advise the government on matters of health and medical policy and to promote the scientific progress of the various branches of the medical profession. The provincial medical boards were administrative bodies, charged by the government with the control of medical practice. They were responsible for the examination of non-university medical practitioners (including pharmacists until 1849),

certification of all medical diplomas, and registration of officially recognized medical practitioners. The provincial medical boards had to enforce the law in medical practice, for which they received limited disciplinary power. Finally, these boards were responsible for the organization of health care in rural areas, for the care of the poor, for supervision of non-university medical schools, for the inspection of pharmacies and other medical stocks, for the encouragement of vaccination, and for action against epidemics and contagious diseases. All these institutions were dominated by physicians. And even in the many proposals for disciplinary councils, pharmacists were always in the minority.

A national association for the defence of the moral and material interests of the pharmacists, the *Association Générale Pharmaceutique de Belgique* had already been established in 1846. This association remained the main voice of the pharmaceutical profession in the 19th century although it suffered from a lack of internal coherence, from passivity and from the intertia of its members. The doctors' national association, the *Fédération Médicale Belge*, was established about twenty years later in 1863. In 1868, the two organizations reached a settlement about the main contentious issues, in the so-called medical–pharmaceutical compromise, and from that date until about 1885 they collaborated in order to obtain from the government a revision of the Law of 1818. Together they established a pension fund for their members. Both organizations gained increasing recognition in government circles from about the 1880s on. Pharmacists usually took part in negotiations with the government, together not only with the physicians but also with the veterinary surgeons. However they generally had fewer representatives than the physicians.

Finally, the absolute number of pharmacists was always well below that of the physicians.[10]

*The division of labour between physicians and pharmacists.*

(a) The medical-pharmaceutical cumulation.

We described above the dispensing arrangement introduced by the Law of 12 March 1818, and the crucial role played by the local medical boards. Local authorities, who administered most public health services, generally showed little enthusiasm or commitment to implementing the new health policies, especially if they had to cover the expenses brought about by them. So it is not surprising that they showed little interest in setting up these local boards. According to a report of the Royal Academy of Medicine, local

doctors opposed their establishment because it entailed the loss of an additional source of income. Pharmacists were, or course, more in favour of these institutions. A few examples are known where they tried to stop dispensing by doctors by the establishment of a local medical board. But because the pharmacies in towns with a local board had to be better equipped than those elsewhere, even for them some losses were involved. The provincial medical boards' views on this matter were somewhat ambivalent. On the one hand, they could delegate some control tasks to the local boards, such as the inspection of the pharmacies, the supervision of non-university medical education and the action against contagious diseases and epidemics. On the other hand, they feared, and not without reason, that the establishment of local medical boards would mean less supervision and less efficiency. Occasionally, provincial authorities forced the local authorities to set up a local medical board but this often led to irregular and apathetic activities (Gadeyne 1979: 175).

The arbitrary nature of the dispensing arrangements was partly responsible for the pharmacists' bitterness about the Law of 12 March 1818. It could happen that a town with 16,000 inhabitants and a sufficient number of doctors, such as Lokeren, had no local medical board, while a smaller town with only 6000 inhabitants, such as Termonde, did have one. Around 1830, there were only 13 local medical boards in Belgium. According to the secretary of the Royal Academy of Medicine, 502 of the 828 pharmacists lived in towns at the beginning of the 1840s. In rural areas there was only 1 pharmacist for an average of 9798 inhabitants against 1 for 2120 inhabitants in the towns. There was no pharmacy in 2216 out of the 2430 communities. In Flanders in particular, there were few pharmacists in the countryside. The opening of an apothecary's shop in smaller towns was usually linked to the possibility of selling chemicals to the local trades and to industry and also depended on whether it was a market town or not (BARM 1845–1846: 124, 132).

The issue of the right of doctors to dispense, one of the main issues of medico-political debate in the 19th century, put a serious strain not only on interprofessional relationships between the medical and the pharmaceutical professions but also on the medical profession internally. Indeed, there tended to be a split between urban and rural physicians, whose interests in this matter were by no means homogeneous. As early as the 1820s, the medically dominated provincial medical boards proposed a ban on cumulation in localities with an apothecary. This viewpoint was put forward in later years by other groups of often influential physicians. There

were a number of commonly used arguments: the first one concerned the inadequacy of rural dispensing. According to the provincial medical boards who were charged with the inspection of the drug stocks owned by physicians and rural surgeons, these rural dispensaries were among the most poorly-equipped and were badly kept. They judged that the rural physicians and surgeons did not possess enough knowledge, competence, or time to prepare drugs adequately.The quality of the drugs dispensed fell below acceptable standards. Second, they judged that the mercantile image given to the medical profession by the dispensing of drugs brought the profession into disrepute. Finally, the dispensing arrangements were thought to force the pharmacists to leave the countryside and settle in towns, where they had to struggle to survive by any means at hand. A ban on cumulation was a way of discharging the towns of their surplus of apothecaries and hence reducing boundary transgressions and competition.

Rural physicians disagreed with their medical colleagues over the extent to which they harmed medical interests. They complained bitterly about the lack of recognition and support from the urban doctors. In fact, they did not challenge the desirability of a clear division of labour between the two professions but rather its feasibility. Their clients were too poor to allow practitioners to survive solely on fees from prescribing. The financial situation of most rural physicians was already only modest, and some even faced poverty. A rural practice in a sparsely populated area involved considerable work for comparatively small returns. Because dispensing was crucial for the survival of these practices, it was also the key to ensure that patients received satisfactory medical and pharmaceutical services. To prohibit dispensing meant to deprive the doctor's clientele of any medical care. Since the pharmacist's role was only a subordinate one, i.e. to see that the doctor's orders were carried out correctly, the doctor took precedence. Thus, one of their principal justifications was the primacy of medical care. The doctor's role was to decide on the need for medical treatment and to supervise the delivery of care. The rural physicians feared that, in a competitive situation, the pharmacists would be more attractive as well as more powerful; they would attract patients because the rural population expected first and foremost a drug or an ointment rather than medical advice or a medical prescription. As one doctor put it:

> Les paysans n'aiment pas à bien solder les visites qu'ils considèrent comme servant d'un délassement, d'une promenade qui ne coûte rien et qu'ils croient la moitié du temps inutiles (Petit 1841: 34).

The pharmacist's position was also more powerful because he could hint that some medical consultations were a waste of money and urge his clients to avoid consulting a physician and thus incurring useless expenses. He could also by disguised or open criticism of the doctor's diagnosis and prescription convince patients to take his own advice. Comments on prescriptions were thus resented and regarded as implied criticism and meddling. A ban or serious restrictions on cumulation would inevitably force doctors to leave the rural areas and to settle in the towns, which implied that overcrowding would be even further aggravated. In the deserted rural areas, the pharmacists would, in their turn, combine the two branches of medicine, with all the prejudicial effects on the nation's health that this implied. In the rural practitioners' opinion, the only choice was between cumulating physicians or cumulating pharmacists, and they had no doubt about which would be the best. It was, of course, in their interest to minimize the prejudices against dispensing physicians and the idea that they did not serve the best interests of the public. Arguments that were commonly used involved medical education, the content of the work, the service to the patients, practical circumstances and their acquired rights. Because of their university education, doctors were all well versed in pharmacy. A pharmacist's examination before the provincial medical boards was hardly more than a formality, and there was good reason to question their claim to superior competence.[11] Dispensing was fairly straightforward. The raw materials were usually bought from a pharmacist in the town, with guarantees as far as quality was concerned.The doctor, who was personally responsible for and interested in the quick recovery of his patient, would carefully check the quality and the administration of the drugs. There was even a psychological advantage in the doctor handing over the medicines he prescribed. In some cases, the immediate availability of drugs was a matter of life and death. The fact that patients could obtain diagnosis, advice and treatment under one roof was particularly helpful to rural patients who disliked long journeys to the nearest shops. Thanks to the doctor's presence in the rural areas, quackery was dying out. Finally, they claimed their acquired rights and noted the different situation in Flanders as compared to Wallonia. Not only was the latter region more prosperous, but its population was also accustomed to pharmacists' presence in rural areas. In their opinion, the pharmacists' hardships were not caused by dispensing physicians but by too easy access to their profession, by the popularity of Broussais[12] and homeopathy – two therapies which reduced drug consumption – by

the sale of secret remedies, and finally by the competition from druggists, herbalists, and perfumers. They were ready to support the pharmacists in their struggle against these 'real' causes of their difficulties.

Leading medical doctors from the professional organizations tried – with gradual success – to reconcile the urban and rural doctors and to gain support for two different policy objectives: first, the reform of the provincial medical boards and the establishment of disciplinary councils, an aim which was strongly though not exclusively favoured by urban doctors and, second, the preservation of rural dispensing, the main concern of rural physicians who were prepared to fight the provincial medical boards because of the latters' criticism of dispensing arrangements. This criticism by the medical boards was interpreted as being an indication of the boards' elitist and unrepresentative character and of their lack of concern for the problems and difficulties of their colleagues.

The resulting more or less united support for rural dispensing arrangements that was given by the doctors' organizations, and even by some leading physicians in the provincial medical boards and the Academy, was bitterly resented by the pharmacists who accused the rural physicians of being only concerned with their own self-interest: 'De l'argent, voilà le devise des cumulards!' According to pharmacists, the physicians failed to recognize the high level of skill they had acquired as the result of extensive training. They pointed out the intricate problems involved not only in compounding but also in the storage and the conservation of drugs. They favoured a clear division of labour. The cooperation of different groups in the treatment process would improve its quality. Doctors were considered to be too self-interested to do the work properly. A dispensing practice required the investment of capital to purchase a stock of drugs, but because a physician could not afford to lose any money, he would be inclined to prescribe only the drugs he had in stock, even if they had deteriorated or were adulterated. In other words there would be a potential conflict between the doctor's commercial need to sell medicines and his professional role in advising and guiding the patient without necessarily recommending a medicine. Moreover, not only did the doctors themselves lack the required knowledge and competence for the pharmacist's work, but they also left the dispensing in the hands of unqualified people, such as their wives or their kitchenmaids. Besides, it would be unwise to concentrate too much power in the hands of one man:

> Ne voyez-vous pas de quel pouvoir terrible, mystérieux, immense vous armeriez le même homme, médecin, pharmacien et vérificateur de décès tout à la fois (De Daméry: 1845: 24).

Finally, a pharmacist would not undermine the viability of rural medical practices because he would never settle in poor, sparsely populated localities.

Both professions searched for adequate criteria to define the conditions under which dispensing would be allowed, such as the distance to the nearest pharmacy, the size and density of the population in a given area, the socio-economic position of the locality, and the customs of the population. Both groups sponsored many petitions to parliament to circumscribe the respective roles of doctors and pharmacists, and for both groups the issue was a strong impetus for organization.

The persisting difficulties between the two professions were one of the reasons why subsequent government bills were shelved. Undeniably, this situation was advantageous for the rural physicians because every new physician settling in a rural area could claim respect for his acquired right in the future. But, on the other hand, doctors were impatient to obtain the reform of the provincial medical boards, so postponement could not go on for ever. After extensive negotiations, a medical-pharmaceutical compromise was reached between the Fédération Médicale Belge and the Association Générale Pharmaceutique de Belgique in 1868. The latter acquiesced to a large extent to the doctors' viewpoint.They accepted that simply to ban cumulation in localities with a pharmacist would cause problems, one of the main ones being the sudden changes occurring in rural areas either because a pharmacy closed or opened. Such changes not only affected the viability of a dispensing practice but could also adversely effect the services to patients. In the compromise it was stipulated that, in the future, the provincial administration could, upon concurring advice of the reformed and elected provincial boards, give permission to doctors to dispense drugs. Every three years the government would draw up a list of communities where the doctor's dispensing right would be terminated by the opening of a pharmacy. Individual doctors would preserve their dispensing right as long as they remained in the same community. The pharmacists also agreed to sell compounded drugs only on prescription, and they abandoned their claim to have the same number of representatives as the doctors in the projected disciplinary councils. In return, they received a promise that the

issue of dispensing would be settled in the near future, a promise of support for their struggle against druggists, against the illegal practice of pharmacy, against several pharmacies being owned by one person, against secret remedies, and against advertising. The period between 1868 and 1885 was a time of relative calm, although some bitterness and suspicion persisted.

Some government initiatives undertaken during the last decades of the century once again focused attention on the problem. The increasing importance of public health and the growing complexity of the required policy decisions fostered the reorganization of the existing government structure. According to the Royal Decree of 31 May 1880, local authorities could establish a local medical board in all communities with at least three physicians or two physicians and one pharmacist.[12] Their main concern would be public health. The decree, which had serious implications for the physicians since dispensing was only allowed in towns without a local medical board, caused considerable unrest. A medical–pharmaceutical congress was convened at which the compromise of 1868 was renewed. After government guarantees, the initial opposition melted away. In 1888, a bill on dispensing caused new unrest among rural practitioners. The government wanted to remove dispensing rights, 'ce privilège exorbitant', from the doctors as far as possible and the Royal Academy and the majority of the provincial boards were willing to concede the change. Dispensing by doctors was now considered less justified than in 1818 because social conditions in rural areas had changed drastically. This challenge to the acquired rights of the doctors aroused hostility in medical circles, however. Thus, the government failed to gain sufficient support for its plan, and the project collapsed.

At the end of the 19th century, the pharmacists tried to enforce their viewpoint. Some young pharmacists challenged local dispensing arrangements and brought doctors who dispensed in towns with a local medical board – there were then 73 such boards – to court. Because the law was clearly being violated, the doctors were convicted of illegally practising pharmacy. However, the pharmacists' victory was short-lived. The representatives of the rural practitioners fought hard to keep the right to dispense. A few even claimed that the physicians should have unlimited access to pharmaceutical practice:

> Le médicament actif est pour le médecin, ce que le bistouri est pour le chirurgien: l'intérêt public veut qu'il puisse manier l'un comme l'autre dès qu'il en a reconnu l'opportunité.[14]

The pharmacists' action met with little sympathy in Parliament, and medical members of Chamber and Senate, although not numerous, were able to make their point. A medical doctor introduced a bill to safeguard the dispensing rights of the physicians. The winning argument stated that the public would be deprived if those medical doctors now dispensing were prohibited from continuing to do so. New limits were, however, established for the future. The provincial administration could give permission for dispensing for five year periods, provided the provincial medical board concurred. These permits would be renewed de jure for subsequent periods of five years. The opening of a pharmacy in the six months preceding the expiry of a permit would interrupt its automatic renewal. In this case, a new application had to be made to the provincial administration. Every physician who obtained the right to dispense before 8 December 1898 could continue his practice as long as he remained in the same locality.[15] More restrictions were judged unnecessary because of the many proprietary pre-packaged drugs, which made dispensing straightforward. The obligation of doctors to buy their drugs from pharmacists, the better pharmaceutical training of doctors, and other legal safeguards were intended to limit the possible dangers of dispensing by doctors. The bill meant in fact a confirmation of the status quo for a considerable time and only slow changes in favour of pharmacists for the future. Only in 1953 was a law on what was called the medical-pharmaceutical cumulation voted by Parliament. This means that medical doctors, even those with a degree in pharmacy, are not allowed to practise pharmacy. A gradually disappearing group of doctors still has a legal stock of drugs.[16]

(b) The sale of proprietary drugs.

On the occasion of the medical-pharmaceutical compromise of 1868, pharmacists and medical doctors condemned the sale of secret remedies, which was considered the modus operandi of charlatans. They also tried to obtain from the government a ban on publicity for drugs of unknown composition in non-scientific journals, but this failed because of the constitutionally guaranteed freedom of the press. Probably at that time it was still difficult to differentiate between proprietary drugs, which clearly improved therapy, and other manufactured medicines, which could be considered as an exploitation of the credulity of the public. In the latter case advertising was crucial. Drug firms gave exotic or pseudo-scientific names, such as Eau de Floride, Baume Indien, Homeriana,

Feltowna, and Elixir de Longue Vie, to their drugs and used the public press to promote their products. The leaders of the pharmaceutical profession found advertising objectionable but they were unable to counter it. They were hostile to and felt threatened by these manufactured medications, which undermined their traditional role of compounding. For a long time physicians showed little interest in activities against these new drugs and even stressed their therapeutic qualities. Indeed, the medical journals were partly financed by publicity for them, to the great dissatisfaction of the pharmacists.

In the 1880s attitudes began to change. According to the Minister of Internal Affairs, a total ban on these products was quite unnecessary. What was required was a clear delimitation of responsibilities for the quality of the proprietary drugs. We need not go into the details of the various proposals here. What they had in common was the emphasis on the pharmacist's responsibility for the quality of all the drugs he dispensed, including the proprietary drugs. The pharmacist's responsibility for the sale of proprietary drugs had already been accepted without any discussion at the medical–pharmaceutical congress of 1880. Hence, the pharmacist remained the key figure in pharmaceutical affairs even though his traditional role was changing. Although this issue has not yet been investigated in depth, one cannot avoid the impression that pharmacists' attractiveness in the eyes of the public was enhanced by the sale of proprietary products and that they fared well by it financially. More and more pharmacists came to consider the name-branded products as a lucrative new field.

In the medical profession, however, the growing supply of proprietary drugs and the rising popular demands for them provoked increasing concern. Doctors feared that self-medication would be stimulated now that clients could purchase a drug in an attractive package with a note giving the directions for use. They would be left behind in the market at a time that the profession was already facing serious overcrowding. The medical–pharmaceutical compromise was now considered to give inadequate protection to medical interests, and the doctors regarded themselves as having been cheated. Pharmacists were accused of the illegal practice of medicine, disloyalty and misconduct. Of course, this did little to promote conciliation. Extravagant demands were made by the Fédération Médicale Belge, such as a radical ban of all proprietary drugs or their treatment as ordinary commercial products that could be sold freely on the market. This would undermine their so-called

scientific character and hence diminish their attractiveness and appeal.

The Minister of Internal Affairs was unimpressed by the medical profession's protests and made it quite clear that it was not the government's intention to accept them. A Royal Decree of 31 May 1885 confirmed the pharmacist's central position in the sale of these manufactured drugs.[17] Another Royal Decree of 1 March 1888 concerning the sale of name-branded drugs ruled that the vendor had to put his own label on the product, except when the pharmacist was the inventor, an exception that opened the door for many abuses.[18] The Fédération Médicale, realising the unfruitfulness of its extremism, changed course and tried to bring all proprietary drugs under medical control. Hence, they proposed that pharmacists should only be allowed to sell a limited number of listed drugs on medical prescription, while the other name-branded drugs could be sold freely by any shopkeeper as ordinary commercial products. Furthermore, they tried to obtain some minor changes, such as the abolition of the right of the apothecary-inventor to keep the composition of his drug secret. The physicians tried to control the sale of proprietary drugs, but they never succeeded completely. Although some of these drugs can only be sold on medical prescription, others can be purchased freely in pharmacies. The exclusive sale in a pharmacy has been and still is considered as a kind of quality label.

(c) The pharmacists' struggle against the druggists.

The Royal Decree of 31 May 1818 recognized the druggists as a separate group. Little is known about them. They were examined by the provincial medical boards possibly after apprenticeship to a recognized druggist. It must have been a small group of practitioners, who seem to have been concentrated in a few provinces. According to official statistics, there were only 189 druggists in Belgium in 1875, 128 of them in the province of Brabant. Their number must have increased rapidly towards the end of the 19th century, because the official statistics mention 541 druggists around 1900.[19] We do not have any knowledge of the existence of a druggists' association to protect their interests.

The Law listed the items they were allowed to sell: simple drugs, spices, colours, mineral substances, animal substances (e.g. honey and fish-glue), and fresh and dry herbs. Chemical substances could only be sold wholesale, and then only those that were not medications. They were not allowed to compound simple drugs. In

general, they were explicitly prohibited from encroaching on the practice of pharmacy. However, the pharmacists accused them of practising pharmacy illegally, in spite of these formal provisions; this practice was not only prejudicial to the people's health but also eroded the pharmacists' economic base. Medical doctors supported the pharmacists in their fight against the druggists, and together they advocated the abolition of the official title of druggist. They stressed that very often unsuccessful students in pharmacy settled for the lower qualification of druggist but still practised pharmacy. The problem became more acute after the Law on Higher Education of 10 April 1890, which made the pharmaceutical training more demanding. This law was expected to reinforce the gradual flow of weaker students to the druggist's shop, which was considered highly undesirable, given the increase in the number of pharmacists. Moreover, the content of the druggists' practice had changed. The sale of non-compounded drugs had diminished considerably since 1818, while, on the other hand, the selling of chemical substances for industry, domestic usage and the arts had increased. Public health was no longer served by the training of druggists, whose pharmaceutical knowledge had never been more than rudimentary, but by better regulation of the commerce in dangerous and toxic products. A circular of 26 November 1892, confirmed by the Royal Decree of 26 February 1895, abolished apprenticeship for druggists. The provincial medical boards stopped examining druggists in 1896.

## Final comments

In this concluding section, we will comment on two themes that are found in the literature on the sociology of professions: the professional dominance of doctors and the historical variations in the division of labour between the professions.

1. Freidson says that pharmacy occupies a niche parallel and unsubordinate to that occupied by medicine (Freidson 1977: 23). As far as the organizational pattern of Belgian pharmacy is concerned, it resembles closely that of the doctors. Pharmacists, like doctors, have specialised knowledge and skills. They are university-trained (university training in pharmacy dates from 1849, 14 years after the medical profession became exclusively university-trained). A degree in pharmacy has been a mandatory requirement for entry into the profession since then. Both now have exclusive licenses by which they monopolise certain tasks. The pharmacists' professional

organization was established nearly twenty years earlier than the doctors' professional organization. Both have disciplinary councils: the order of physicians was established in 1938, but only became active after the Second World War; the order of pharmacists was established in 1949. Both professions have a code of ethics. Together they were and are involved in policy-making bodies, such as the Royal Academy of Medicine and the provincial medical boards, and in private initiatives, such as the Belgian pension-fund for medical practitioners. By the early decades of this century, medical practitioners and pharmacists alike were faced with a growth in demand and a need to expand their skills. And both professions were increasingly affected by health insurance funds.

One could go on pointing out similarities in the professional organization of the two groups.

One critical difference remains however: medical practice was considered the basis of medical treatment and therefore was given priority in the treatment process. The state sanctioned an organization of labour that promoted medicine's control over clients and potential rivals. The pharmacists' work is not entirely but to a large extent determined by, and dependent on, the doctors prescribing behaviour. Johnson has written that 'occupational activities vary in the degree to which they give rise to a structure of uncertainty and in their potentialities for autonomy' (Johnson 1972: 43). Compared to pharmacy, medicine has greater potential for autonomy and for influencing the division of labour.

The example of Belgian pharmacy, however, illustrates that it would be ill-advised to stop short of the establishment of medical dominance and autonomy. Pharmacists have never really sought to expand their territory beyond the control of pharmaceutical matters nor to challenge this specific aspect of medical dominance. Their main preoccupation was with the geographical expansion of their officially recognised monopoly (from urban to rural areas) and in this they had to adjust their aspirations at least as much to the pressure of socio-economic circumstances as to the influence of the dominant profession. They were not allowed to threaten the medical profession, but there were also clear restraints on the role of medicine in pharmaceutical matters. When measuring each professional organization's success, one has to take into account which issues were involved. For example, in the case of dispensing by medical practitioners, the medical profession was for a long time successful in fighting the contraction of their traditional role, but in the case of proprietary drugs it was largely unable to influence

developments, partly because the government regarded the pharmacists as being the competent body to handle them. In the 1880s, the state rejected the means of controlling proprietary drugs put forward by doctors, and instituted registration in the face of the doctors' opposition. Furthermore, to look only at the medical division of labour may lead one to underestimate the power of the pharmaceutical profession. Pharmacy is a successful profession in its own right, that has managed to maintain its own identity in the face of influences from large drug companies and to drive lower groups, which emphasised the commercial aspects, out of the market. The reduction in the need for medicines to be compounded by pharmacists has altered their position but not diminished it. It has been matched by the emergence of a new role as guarantor of quality of all kinds of drug. This exemplifies, firstly, the fact that professional institutions and professional privilege are relatively well protected against erosion and tend to persist over time (Rueschemeyer 1986: 107). Secondly, it also illustrates Larkin's thesis that 'professionalising stratagems include other objectives than simply the immediate achievement of autonomy or control in the division of labour' (Larkin 1983: 191 ff.).

2. The social construction of the division of labour between occupations has to be seen as a historical process.

As in England, combined practice of the different branches of medicine was prohibited in the large Belgian towns in the Ancien Régime.What was clearly different from England however was, first, the position of the *collegia medica*. These cannot be considered simply as medical institutions like the Royal College of Physicians. The medical colleges, although probably to some extent dominated by physicians, were mixed bodies. The physicians did not have a corporate organization of their own, unlike the surgeons and the apothecaries, who were affiliated to their guild or company. Another difference was that physicians were apparently never in short supply in these towns, at least not according to Broeckx and some other sources. According to Kronus, a shortage in the number of physicians for the middle and lower classes partly explains the rise of the apothecaries in the 17th century (Kronus 1976: 12 ff). It could well have been that this joint responsibility for the supervision of medical practice and the adequate supply of physicians in Belgium contributed to the comparatively greater respect for the established division of labour. What is certain is that Belgian pharmacists never gained legal sanction for the practice of medicine, as did their English counterparts as early as 1703 in the celebrated Rose Case,

although some involvement in the practice of medicine seems to have been allowed by town authorities. The separation of medicine and pharmacy in towns was not affected by the subsequent changes in political regime.

In smaller towns and rural areas, general practice, including dispensing, was the rule. As in England at that time, there was little differentiation between the activities of prescribing, compounding, and selling drugs. Following the laws on higher education of 1835 and 1849, the educational level of these 'general practitioners' was upgraded, but the traditional pattern of practice probably remained largely unaltered. Although dispensing by medical doctors was the most common pattern in large parts of the country and especially in Flanders, separation between medicine and pharmacy was considered the ideal pattern of practice by legislators, segments of the medical profession, and, of course, the pharmaceutical profession. The main issue of debate was to establish when and where this ideal division of labour could be implemented.

3. One could argue that the Belgian pharmaceutical profession is the heir of the old apothecaries' company of the Ancien Régime. There was no assimilation of pharmacists into the medical profession and a clear distance was also kept from the lower level druggists. In England, on the contrary, 'the apothecaries had left their shops and become doctors. The druggists had stayed in them and became pharmaceutical chemists' (Kronus 1976: 16). These events in the past might help to explain the more professional image of the Belgian pharmacists compared to the British. Even today, British pharmacies have a wide range of goods on sale, such as perfumes, candies, sun-glasses, and cameras, and not just drugs and products related in one way or another to health. It illustrates that the Belgian pharmaceutical profession's niche, although to some extent similar to that of pharmacists in Britain, is somewhat more prestigious and perhaps more comfortable.

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**Abbreviations**

BARM: Bulletin de l'Académie Royale de Médecine
FMB: Fédération Médicale Belge

## Notes

1 In this paper, the term 'doctor' refers to the title of 'Doctor of Medicine, Surgery, and Obstetrics', instituted by the Law of 15 July 1849. It is equivalent to the term 'physician'. In the context of the 19th century, the term 'medical profession' refers to the group of university-trained medical practitioners.
2 For more details see Schepers, R. (1985), 314–341.
3 The fourth important group were the midwives. This group was not only under medical but also under ecclesiastical jurisdiction, because religious conformity of the midwives was considered crucial to secure the baptism of the new-born child. There were also numerous itinerant practitioners who practised particular specialities, such as dentistry, ophthalmology, and bone-setting.
4 During the 17th and 18th centuries, collegia medica were established in Antwerp (1620), Brussels (1650), Ypres, Ghent (1664), Kortrijk (1683), Mechelen (1699), Liège (1699), Dendermonde (1754), and Bruges (1760).
5 *Pasinomie*, 1st series, vol. 12 (20 February–17 May 1803) p. 12, 19 ventôse an XI: Loi relative à l'exercice de la médécine.
6 The Hague, Internal Affairs, Medical and Veterinary Policy, Inventory number 712, file number 161, 7 October 1817.
7 *Pasinomie*, 2nd series, vol. 4 (1817–1818) p. 343, 12 March 1818: Loi réglant tout ce qui est relatif à l'exercice des différentes branches de l'art de guérir.
8 The title of doctor of pharmacy was abolished in 1835. Pharmacists could become doctor in the natural sciences.
9 *Le Scalpel*, 49, 1 (5 July 1896).
10 *Exposé de la situation du Royaume*, (1841–1850), (1875–1900). In 1831, the density of physicians and surgeons was about 4.79 per 10,000 inhabitants versus 1.69 pharmacists. In 1900, there were 5.29 medical doctors per 10,000 inhabitants versus 2.80 pharmacists.
11 After 1849, pharmacists were no longer examined by the provincial medical boards.
12 Broussais, F.J.V. (1772–1838) doctrine insisted that all diseases originate as an irritation of the gastro-intestinal tract that passes to other organs 'sympathetically'. Broussais' doctrine has been popular at the University of Louvain.
13 *Pasinomie*, 4th series, vol. 15 (1880) pp. 234–40: Réorganisation des commissions médicales provinciales et locales.
14 *La Gazette Médicale de Liège*, vol. 10, no. 40 (7 July 1898).
15 *Pasinomie*, 4th series, 34 (1899), 28 February 1899: Loi relative au cumul des professions de médecin et de pharmacien.
16 According to the *Statistical Yearbook of the Ministry of Health* there were 322 doctors (out of 26,593) with a stock of drugs in 1982. For the majority of them, i.e. 237, it was an acquired right.
17 *Pasinomie*, 4th series, 20 (31 May 1885) p. 171: Royal Decree concerning approbation of the new instructions for doctors, pharmacists, and druggists.
18 *Pasinomie*, 4th series, 23 (1 March 1888) p. 41: Pharmacopeé Officielle. Vente des spécialités pharmaceutiques.
19 *Exposé de la situation du Royaume*, vol. 2 (1876–1900) p. 160.

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