A History of Bristol Medical School

A History of Bristol Medical School:

Personal and Collected Experiences of Students and Staff

By

David J. Cahill

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The beginning and development of medical education in Bristol

The earliest recorded activity in teaching medical students in Bristol is in the Bristol (Royal) Infirmary when it opened in 1735, with some scattered evidence of teaching by apprenticeship prior to that. This book traced the changes in how and where students were taught over the past 250 years, and the efforts required to provide the medical school with a modern and responsive curriculum, fit ultimately for the 21st century. This chapter also shows pictorial evidence as far as it is available of the structures and buildings over time that are part of this process. Appropriate recognition of the input of those who have written extensively on this subject is provided, together with reference material for other published work which supplement the work of Bruce Parry and Munro Smith.

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positively. In additional to the Faculty Deans, those involved in pastoral care, curriculum development and student discipline are included – these are the pre-clinical deans and the clinical deans (in the early days, there were clinical deans in all three Bristol Hospitals, until the late 90s). Those involved as Clinical Deans continued largely to have an interest in undergraduate education. The Faculty elected its first female Dean in 2019.

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FOREWORD

The topic of this book is the history of Bristol Medical School and more specifically the undergraduate medical programme, up to the present day. Officially, the starting point of this story is 1980, but it is impossible to start a history of something so organic without recognising the rich, varied and often challenging prior history of the school, moving as it did around the city in the 1850s-1950s, the subject of much political manoeuvring and plotting. It is fascinating to read of the efforts of the people who strived to provide the school with a firm foundation. The book describes challenges including the overcoming of resistance within the ranks of academics, responding to the changes in the educational environment that have been brought to bear over the timespan of the book, and recognising the role of the student within the educational environment, working with them to improve the process and outcomes of their training.

The power of narrative or stories is to engage us and draw us in, to allow us to connect with facts on an emotional level. In medicine we know that the patient's story will often tell us not only what is wrong but also what the patent is worried about and what they are looking for in their interaction with the doctor. This book is for those interested in the story of Bristol Medical School. This could stem from an interest in medicine, history, the City of Bristol or the evolution of an institution and the people who shaped it. It is relevant to alumni, students, and staff as well as those interested in the topics above. There is no other published history of the medical school covering the period from 1980 so this a unique resource.

So, why should you read this book? This is in essence a 'feel good story' in a time when health, healthcare and the NHS has faced a once in a century challenge from a global pandemic. Bristol medical students and alumni have been caring for those affected selflessly, some graduating early from their programme in 2020 and staffing hospitals, public health services and primary care across the world. Academics from Bristol Medical School have shaped the national UK and worldwide response to Covid 19 through research on the virus, its spread, preventative measures, and vaccines.

This book is not only a celebration of the endeavours of the staff and students at the Medical School, but also a contemporaneous account by

someone who was embedded in, indeed for many years, who embodied the Medical School as its very popular Medical Programme Director and a highly regarded professor of reproductive medicine and medical education. Professor Cahill's first-hand knowledge is combined with research including first-hand accounts from those involved with the more recent story of this venerable institution. It is therefore grounded in real events but brings with it the enjoyment of a tale – a tale that ends happily but as with all good stories has its share of highs and lows along the way.

Sarah Purdy October 2021

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I am very grateful to my wife Eileen who has allowed me to write another book, all the while knowing how much time it would take.

Without a doubt, there are errors of omission and of commission in this book. To realise even in the last few days before it was sent to the publishers, that there were gaps in the knowledge is humbling. That will be for the next person to put right. But it is A History, not The History. And while this book encompasses more detail than Bruce Perry's did, so will the next volume on the topic add to what is in this book. The image on the front cover, the arms of the Bristol Medical School, has been used in various settings: it is over the door of the Geographical Sciences building on University Road and Bruce Parry used it in his 1984 history book. It was designed by George Downing Fripp around 1840 and is first recorded, I believe, in Prichard's paper (Bristol Med Chir J 1892; 10: 264-291). The image is of the old arms of Bristol, with Aesculapius, Greek god of medicine on the left and his daughter Hygeia (Greek goddess of cleanliness) on the right.

The following people were written to and responded orally or in writing: Nicola Taylor, Gareth Williams, Colin McInnes, Norman Tricks, Alice Roberts, Robert Slack, Jane Blazeby, Viren Ahluwaliah, Hugh Sims-Williams, Geoff Clarke, Andrew Blythe, Michael Whitfield, Trevor Thompson, Shanze Ashai, Guy Morris, Eugene Lloyd, Sarah Purdy, David Mumford, Brian Pickering, Gordon Stirrat, Nigel Rawlinson, Anna Taylor, Helen and Philip Nicholson, Harrison Carter, Marie Edison, Zoe Bakewell, John Kirwan, Chris Probert, Peter Fleming, Jonathan Sandy, and Ian Silver. Their being willing to reply to or meet with me has made this book all the richer for its links to reality.

Mr. Richard Kielb, Medical Subject Librarian got me on the right track in correct identification of all the Faculty Deans and Ms. Karen Anderson, Archivist at the University's Special Collections and her team gave me all the access to documents that I required, even with pandemic restrictions.

The following individuals took the time to read, proofread and comment on the text: Mrs. Wendy Hammonds, Ms. Ailisha O'Sullivan, Dr John Black, Dr Peter Carpenter, Mrs. Zahra Spiller and Prof Paddy Horner. In addition,

Dr Peter Carpenter, as a medical historian, provided many useful bits of detail which were invaluable.

Chance contacts with individuals opened new vistas. Email correspondence with Ms. Megan Butler provided some detail on her parents Mary Jacobs (MB 1942) and Robert (Gregor) Shanks (MB 1940) (Their class photo is Figure 8.1). Enquiries about the likely site of "Long Jack" Vernon's hanging (Chapter 1.1.7) to the Kingswood Historical Society provided me with contemporaneous newspaper reports on the events and a copy of a booklet published in the 1960s by Mr. Fred Cross, *A Panorama of the Bristol Medical School*.

The lists of those who provided help and support above do not reflect the overwhelming enthusiasm and excitement everyone has shown when they were helping me. It is humbling to recognise that while I have stitched this patchwork together, the piecework has come from multiple individuals to whom I and you should be grateful.

David J Cahill
February 2022

ABBREVIATIONS

3D	The vertical theme in the curriculum of Diversity, Disability and Disadvantage, initially introduced by Dr Margaret Byron.
ALSPAC	The Avon Longitudinal Study of Parents and Children, which was initiated in the early 1990s by Prof Jean Golding, and also called Children of the 90s.
AMD	Academy Medical Dean, the first person in all academy teaching sites to be appointed, with details of individuals appointed in Table 5.2.
AMEE	The Association for Medical Education in Europe, an international organisation which hosts a yearly conference where research work is presented and discussed
ASME	The Association for the Study of Medical Education with UK roots, set up to encourage, promote, and conduct research into medical education
BCDE	The Bristol Clinical Data Examination, see Chapter 3.1.7 for more detail
Best-of-5 MCQs	A form of examination question in which only one answer is correct
BRIG-H	An early cross Bristol city research group, Bristol Research and Innovation Group for Health
CAPS	**C**linical **A**nd **P**rocedural **S**kills Handbook- A handbook which required completion from Year 1 to Year 5, which encompassed all the core skills required by the General Medical Council on graduation
CSL	Consultant Senior Lecturer
CTF	Clinical Teaching Fellow, a junior doctor employed by a hospital whose role was to undertake teaching and clinical work specifically

Deanery	A structure set up by the NHS's educational arm to breakdown the country's hospitals into manageable units with budgets. Today, each Deanery (e.g., Severn - the one equivalent to the University's teaching hospitals and GP practices) has Schools, which look after postgraduate training in Medicine, Surgery, Paediatrics etc.
EPM	Educational Performance Measure of skills and knowledge performance over three academic years (in Bristol) in deciles for which 34-43 points are available, which with the Situational Judgement Test form the ranking for Foundation Year jobs.
ERASMUS	This is the European Community Action Scheme for the Mobility of University Students, designed to facilitate movement of students between universities and for us, specifically between medical schools.
Fit2Teach	A short educational course delivered locally and aiming to prepare staff in the academies and faculty for teaching, assessment and the support of learning
GMC	The General Medical Council, the country's major regulator of medical practice and medical education
LiTHE	A four week block at the end of Year 2, Learning in the Hospital (later Healthcare) Environment was designed by Dr Nicki Cohen to bridge the gap between the science based Years 1 and 2, and the clinical years, Years 3 onwards.
MB ChB	The primary conjoined degree awarded after successful completion of the undergraduate course, which means Bachelor of Medicine, Bachelor of Surgery
MB16	A phrase coined in 2016 to describe the system-based curriculum of the undergraduate degree course
MB21	A phrase coined in 2014 to describe the new case-based curriculum of the undergraduate degree course.
MCQ	A term used to describe any type of multiple-choice question, whether best-of-five or the older multiple true false questions, or variants thereof

MERC	Medical Education Reform Committee, see Chapter 7.3 for details
MMC	Modernising Medical Careers, a programme for selection for postgraduate medical training and the organisation that ran it
MUT	Medical Undergraduate Tariff, the amount of money coming to a hospital from the Dept. of Health for hosting medical students
MWSAC	Medical Workforce Standing Advisory Committee, see Chapter 5.2 for details
NSS	The National Student Survey, carried out annually by all students leaving higher education, to collect data on the experience. It is used as a marker of the quality of student experience.
OSCE	An Objective Structured Clinical Examination, in which students move from exam station to station sequentially and have a series of clinical tasks to undertake at each station
QAA	A national body, the Quality Assurance Agency for Higher Education has the power to withhold a university from awarding degrees
RAE	The Research Assessment Exercise was a means of quantifying the quantity and quality of a university, faculty, or department's research output.
RCPI	The Royal College of Physicians in Ireland, founded in 1654
RCSEng	The Royal College of Surgeons in England (London) founded 1800
REF	The Research Excellence Framework, successor to the RAE (above) and see Chapter 2.3.1 for details.
SIDS	Sudden Infant Death Syndrome, a.k.a. cot death, a preventable cause of infant mortality. See Chapter 4.2 for more details.

SIFT	Service Increment for Teaching, explained in full in Appendix 2.1
SJT	A national examinational for all medical students to undertake, the Situational Judgement Test assesses expected performance in differing clinical scenarios, and is added to the Educational Performance Measure (as outlined above)
SSC	Sections of the curriculum in which Student Selected Components are exercised by students to follow independent learning over a wide range of topics: Medical French; Disability at Sea as examples
TASME	Trainees' Association for the Study of Medical Education, a formal offshoot of ASME, designed to foster cohesion and collaboration in education across trainees
TEF	Teaching Excellence Framework, explained in Chapter 2.3.1.
THES	Times Higher Educational Supplement, a separate publication by the Times group focussed on higher education, and responsible for production of one of the annual unofficial league tables for medical schools (See Table 2.1)
TLHP	Teaching and Learning for Health Professionals, Bristol's postgraduate course in education for medical and allied health professional to supplement and develop teaching and learning skills in the workforce
UMeP	The Undergraduate Medical ePortfolio, introduced by Nigel Rawlinson, as part of a cross medical schools exercise, mirroring the portfolio which students complete as foundation year doctors, and capturing records of skills acquisition through the programme, career reflections and other markers of performance

CHAPTER 1

THE BEGINNING AND DEVELOPMENT OF MEDICAL EDUCATION IN BRISTOL

This introductory chapter brings the reader from the very earliest days of Bristol Medical School from the 18th century, right up to the near present – the 1970s and 1980s. The remaining chapters in this book cover the time span from about 1980 to 2020, a relatively short time in history, but a period which saw fundamental changes in the structure and management of the medical school. These changes meant teaching with lower staff numbers, a hyperbolic increase in student numbers, and a radical change in the way that teaching was delivered. Apart from the Introductory Chapter, the material in this book is derived from interviews with staff members and students, and publications as well as my own recollections. I am hugely grateful to the many individuals - previous and current staff and students - who have contributed content. They put flesh on dry bones to make this a living story.

The major source materials for this chapter are listed in the references of course but are also given in the bibliography at the end of this chapter. One is a slim book written by Charles Bruce Perry, Professor of Medicine in Bristol for 36 years until he retired in 1969 (Bruce Perry 1984a). Like several of his successors, he could "strike terror in the hearts of his students" but he was also a "kind, sincere, and considerate man whose one desire was for their welfare", or so his obituary records it (Coles 1996). Other important and accessible records were written by George Munro Smith (G.M. Smith 1917), Michael Whitfield (Whitfield 2016), Robert Milnes Walker (Walker 1975), Augustin Prichard (A. Prichard 1892) and Michael Neve (Neve 1984a). The archives of the Bristol City Council and of the University are further useful sources (http://archives. bristol.gov.uk/).

Bruce Parry's book "The Bristol Medical School" (Bruce Perry 1984a) was based on a lecture he gave in 1984. The closing paragraph of the book refers to the progress the medical school had made over the years to be very successful if measured against the numbers of applicants to the medical school. This was a prophetically negative statement in some ways – the

belief that numbers of applicants to the medical school was the measure of success continued to be firmly held by many members of staff over the years from then until near the present day. It convinced many in the medical school that change in approach and attitude was not necessary, and it fostered resistance to change – despite poor inspection reports from the General Medical Council and poor results in the National Student Survey. These will be explored in later chapters.

A 1917 work by Munro Smith (G.M. Smith 1917), although entitled "A history of the Bristol Royal Infirmary" actually covers the early history of medical undergraduate teaching in the 18th and 19th century. It illustrates that the early drivers for medical education came from doctors. It includes the (sometimes unbelievable) escapades of the resurrectionists, suppliers of anatomy material to the medical school and the antics of medical students (2). George Munro Smith himself (1856-1917) was a surgeon in the BRI and a Lieutenant Colonel in the Territorials (as part of the RAMC). In his introduction, he speaks a great deal of his namesake, Richard Smith (Surgeon to the Infirmary from 1796 to 1843), who collected much of the material in his book "A history of the Bristol Royal Infirmary" but reveals little of himself. However, we should be grateful to him for doing so and providing such a record. Obituaries for Munro Smith in the BMJ and Bristol Medical Chirurgical Journal in 1917 (Anonymous 1917a, 1917b) show that he grew up in Bristol and went to Bristol Medical School where he got gold medals in surgery and medicine. He later became an anatomy and physiology demonstrator and then became a surgeon in the BRI in 1897 but in addition, as it were, in his spare time Professor of Physiology in University College, Bristol, from 1893 to 1899. The history of dental teaching has a more recent history (first in 1888) and been written by Chris Stephens (Stephens 2010). Munro Smith, in his book (page 392)(G.M. Smith 1917), wrote of dentistry perhaps dismissively:

> *"The advantage of having a properly equipped department with expert dentists, and the many accessories necessary for tooth extraction, etc., was at once apparent, and the shrieks associated with this branch of surgery became confined to certain days".*

1.1. The beginning

In the mid-1700s, there were three broad classes of medical practitioners – the Physicians, the Surgeons and the Apothecaries. In 1754, Harsant states there were four categories or guilds of medical practitioners in Bristol - the apothecaries, the barbers, the barber surgeons, and the physicians - 5

physicians, 19 surgeons, 13 barber-surgeons, and 29 apothecaries, making a total of 66 (Harsant 1899). Fissell provides higher figures: 70 apothecaries, 160 surgeons and 5 physicians (Fissell 2002).

It would seem from the records that there was frequently discord amongst all these groups. Apothecaries, some of whom developed into what were in later times general practitioners and some into community pharmacists, served a seven-year apprenticeship before being allowed to practise. After a seven-year apprenticeship, surgeons could treat fractures and injuries and they removed kidney and bladder stones.

1.1.1 Physicians, trained in universities

Physicians were trained in the ancient universities in the UK (Oxford, Cambridge) and in Europe. Surgeons and Apothecaries on the contrary were trained locally by apprenticeship. That training brought differences in attitudes and ideas about station. In addition, physicians considered that they gave direction to surgeons (to cut) and to Apothecaries (to treat with medications). Those differences were very much in evidence in urban settings; in rural settings, boundaries were often, of necessity, blurred. The tale of John Westover, a surgeon in Wedmore, Somerset between 1686 and 1700 describes the multiplicity of ailments that he catered for (Hall 1990); Burnby cites several examples of this "fusion" of roles throughout the 1600s and 1700s (Section II, Chapter 1)(Burnby 1979). Physicians training in university certainly underwent a prolonged period of training: with four years for a BA, three for an MA, then at least a year of university lecturing, then four years for an MB, and two further years for an MD – 14 years in total (Burnby 1979). The Royal Colleges of Physicians in London, Edinburgh and Dublin were all founded from 1520 to 1650. Membership of these colleges was a prerequisite to being a practising physician and was an excluding barrier to all others. Surgeons and apothecaries allied themselves in Guilds which had legal status and charters in cities like Bristol, and charters offered some protection to their trade.

Physicians, who numbered five in the city in the mid-1700s, were generally regarded (certainly by themselves) as being the cream of the medical profession. Ward rounds were generally conducted by physicians, but not apothecaries. Medical and nursing readers over the age of 55 may recall the theatrical and commanding impact of ward rounds with the physician in his three-piece suit with carnation in the buttonhole, but the physicians of the 1750s outdid them in sartorial glamour by being bewigged, and frequently armed with a rapier strapped to the waist. William Logan, one of the first

physicians in the Bristol Infirmary, was never seen without his "head covered by the immense flowing wig of George II's time, a red roquelaire (cloak) hanging from his shoulders to his heels, his wrist graced by a gold-headed cane, and his side furnished with a long French rapier" (Harsant 1899).

The relationship between physicians and apothecaries (see 1.1.3) nationally varied between cool and stormy. The issues that gave rise to this included territorial demands, attempts by the physicians to restrict the practices of the apothecaries, and the apothecaries' resistance to them. As an example, when the Plague hit London in 1665, the physicians all fled but the apothecaries stayed behind. Afterwards, the physicians were to say the least upset when the apothecaries did not want to give up the practice grounds they had gained in the absence of the physicians. This led to a curious episode called "The Pamphlet War", salvoes in writing from one side to the other waged between 1669 and the late 1670s (Burnby 1979). Indeed it would appear the populace had begun to vote with their feet: "the people generally had begun to regard the apothecary as their legitimate medical attendant, in their opinion well qualified for the task" (Burnby 1979). The "Pamphlet War" continued until Charles II brought both parties to order in 1684, though animosity didn't come to an end.

1.1.2 Training by apprenticeship

There are some records of medical practitioners being trained or educated in Bristol prior to the opening of the Bristol Infirmary (now the BRI) in 1737 (Queen Victoria gave the hospital its Royal Charter in 1850.) Medical training almost certainly also happened in St Peter's Hospital (see below, 1.2.4), but no account of it survives (Bruce Perry 1984a).

In his book, Bruce Perry speculates that medical training at the Bristol Infirmary was undertaken by a resident medical professional, the Apothecary, who took on medical apprentices. An Apothecary is/was someone who formulates and dispenses medicines to other practitioners and to patients, following completion of an apprenticeship. The Resident Apothecary at the Bristol Infirmary had the sole medical charge of the patients during the absence of the Physicians and Surgeons; he had also to send out notices of accidents, emergencies, etc. to the Staff, do a great deal of the "dressing" of wounds, carry out the orders for cupping and bleeding, and dispense many lengthy prescriptions (G.M. Smith 1917).

Surgical apprenticeships were taking place as early in the 1500s (Richard Ben, from Castle Combe in Wiltshire, apprenticed to William Bens, Barber Surgeon in 1533; John Colemore of Bristol apprenticed (in 1541) to a surgeon, Christopher Hatton (Hollis 1949)) and on to 1719 and 1720 (to Samuel Pye and William Hargest of the Barber Surgeons Company in Bristol) (Ancestry Ireland Unlimited Company 2021). Both Pye and Hargest are mentioned in Milnes Walker's article on *The Barber Surgeons of Bristol* (Walker 1975). However, the setting up of the Bristol Infirmary provided a focal point for those apprenticeships to be located somewhere physically. Surgical apprenticeships in the Infirmary with a Barber Surgeon were introduced a little later (Bruce Perry 1984a). In his book, "A history of the Bristol Royal Infirmary", Munro Smith notes 7-year surgical apprenticeships were in place by 1744, apprentices paying considerable sums to the surgeons for instruction. The fee for the first year was 40 guineas, and fees rose for each successive year. Forty guineas in today's money would be just under £10000 (in 2020)(G.M. Smith 1917) – which puts current tuition fees in perspective.

In the late 1780s, the Bristol Infirmary underwent a major refurbishment (G.M. Smith 1917) and expansion which provided more teaching space in the building and giving the building the familiar shape, which today is called the "Old Building" – now decommissioned from clinical service and being transformed into accommodation.

In addition to the Bristol Infirmary, students were also taught/apprenticed at St Peter's Hospital. This was built in the 1400s as a large dwelling house, adjacent to St Peter's Church in the present-day Castle Park area, between the river and the church. Robert Allworth bought it in 1607 and rebuilt it. About 1634, it was owned by Thomas Elbridge, and soon after it became the Bristol Mint. It was bought by the Corporation in 1696 for £800 to be used as a workhouse for the Bristol Corporation of the Poor and it is in this role as a paupers' workhouse that the building is much better known. It was called St Peter's Hospital in 1820. At this time, St Peter's acted as the lunatic asylum and as the poorhouse. Imagine what the conditions must have been like. After the cholera outbreak of 1836, overcrowding led the Corporation of the Poor to rent the defunct Napoleonic prison at Stapleton, thereby founding Bristol Lunatic Asylum, later Blackberry Hill Hospital. The ordnance survey maps of 1880 show two separate buildings, Bristol Union Workhouse and the Bristol Lunatic Asylum (Bristol). Both St Peter's Church and Hospital were destroyed in 1940 in WW II. The ruins of the church can still be seen, but there is no trace of the hospital, which was situated between the church and the river.

1.1.3 Apothecaries

The apothecaries had previously been in the Guild of Grocers, but the Grocers and the Apothecaries fell out: this was partly due to the Apothecaries having no representation on the council of the Grocers, and in 1612, they petitioned the king about "the dangers which arose from unskilful persons making and selling ... corrupt medicines in and about London" (Burnby 1979). The Society of Apothecaries of London was incorporated in December 1617 and the Apothecaries formally separated from the Grocers in 1624 (The Worshipful Society of Apothecaries 2020). That 1612 charter was countersigned and approved by the Royal College of Physicians included references forbidding several activities by the Apothecaries including "They were not to visit patients to give advice or administer treatment except in urgent cases when no registered physician was available". Then, in 1703 or 1704, the Society of Apothecaries won a case in the House of Lords against the Royal College of Physicians (the Rose Case - Rose v Royal College of Physicians), gaining the right for Society members to both prescribe and dispense medicines (The Worshipful Society of Apothecaries 2020), but interestingly they were not allowed to charge for the advice or prescription, only the medicines. Prior to that, apothecaries could charge to dispense medicines but could not give medical advice – only physicians could do that.

Like Surgeons, apothecaries were apprenticed before formal hospitals were established – in 1549, Edward Johnson, from Anglesey, was apprenticed for 10 years to a Bristol apothecary, David Harris (Hollis 1949). Other named apothecaries in Bristol include Standfast Smith, in Corn Street, elected to be a freeman of the city in 1738 and also apothecary to St Peter's Hospital (Whittet 1964). In Bristol, it appeared that the apothecaries shared the Barber Surgeons' accommodation on Exchange Avenue (and may have been members) (Whittet 1964), and Standfast Smith held the mortgage for the building (Whittet 1964). In her thesis, Juanita Burnby suggests the physicians in Bristol were also members of the Barber-Surgeons guild (Burnby 1979), but corroborative evidence is so far lacking on this.

It is said frequently that the apothecary later evolved into today's general practitioner in medicine, but that statement is worth examining further. As such, the term general practitioner did not come into use until 1830 (Anonymous 1830). There was a major increase in the country in medically and/or surgically qualified practitioners in the years following the end of a long series of military conflicts – in the American War of Independence, French Revolutionary War and then in the Napoleonic Wars. And these

returning men from the wars, by an Act passed in 1745, were allowed to set up practice without any time spent in apprenticeship (Burnby 1979). There was then a long period, 30 years or more without major military conflict. The increase in "doctors" caused a glut in medical practitioners across the country and led many to set up practice in towns and villages, to survive. The freedom of these largely naval retirees was enshrined in several acts of parliament, making it almost impossible to impose any control on them (Burnby 1979). This added pressure on the need to bring about some regulation of these practitioners, part of which led to the Apothecaries Act.

In 1815, the Apothecaries Act was passed, having been proposed by the Society of Apothecaries and supported by the Royal College of Physicians (Holloway 1966). The need for this Act came about because by the 1750s, not all apothecaries, but "*the majority of town apothecaries and practically all those in the country attended patients of the poor and lower middle-class, prescribing and supplying medicines to them*"(Holloway 1966). The apothecary had become to the poor what the physician was to the rich, and their development into registered medical practitioners was enhanced by the 1815 Act. Indeed, the preparation of medicines was now falling to chemists and druggists (in the late 1700s) and they and apothecaries did not heap praise on each other

> *"chemists were accused of selling and using impure foreign drugs, leaving out of expensive and complicated formulae all the costly ingredients. On the other hand, the 'monstrous profits' of apothecaries, their incompetence, illiterate character and dishonest practices are portrayed with no sparing hand" (Holloway 1966).*

Part of the Apothecaries Act was to increase the control and supervision of apothecaries, by which they should be *at least twenty-one and have studied physic in a school for one year after serving a five years' apprenticeship ("The Apothecaries' Act of 1815" 1851)*. It introduced an examination and a course of study to be followed, in Anatomy and Physiology, Chemistry, the Theory and Practice of Medicine and Materia Medica (that being the study of medicinal substances or remedies) (Society of Apothecaries 1829; Hawthorne 1895).

1.1.4 Surgeons and Barbers

In 1540, in London, the Fellowship of Surgeons (documents refer to this group variously as the Guild, the Fellowship, the Company and the Faculty) and the Company of Barbers joined to form the Guild of Barber-Surgeons.

Barbers were skilled in the use of razors, knives, and scissors. In earlier medieval years, members of ecclesiastical orders provided much care for the population including doing surgical procedures. The dissolution of the monasteries after Henry VIII led to this care no longer being provided, but even before that, in 1131, the Pope had ruled that those in holy orders were banned from drawing blood (Amundsen 1978). This led to clerks and barbers beginning to take on minor tasks such as lancing boils and pulling teeth, though it is likely that the appetite for more challenging tasks led to them undertaking procedures beyond those minor ones. In the 1400s, in the campaign against the French, Henry V gave the Faculty of Surgeons authority to press others into service to assist, and such exposure for Army surgeons brought skills in fracture reduction, amputation, and wound closure.

Thomas Vicary (1495-1561) was the architect of the union between the Fellowship of Surgeons and the Company of Barbers. A surgeon and Master of the Fellowship of Surgeons on several occasions, he was also "Serjeant-Surgeon" to several Kings and Queens (Robinson 1984), and had apparently cured the "sore leg" of Henry VIII (page 31) (Dobson and Milnes Walker 1979). (Serjeant-Surgeons were and are the senior surgeon in the Royal Household, *serjeant* not referring to a military rank but related to the Latin word *serviens*, meaning serving. The current holder of the post, since 2016, is Mr. Satyajit Bhattacharya, a London hepato-pancreato-biliary surgeon) ("Serjeant-Surgeon" 1940). The agreement for the union between Barbers and Surgeons was designed to ensure that surgeons did not act as barbers, and barbers did not take on surgery, and all examinations and licensing of surgeons was the responsibility of the guild. All surgeons were to put up a sign in the street so that people would know where they could go for their treatment (the familiar red and white striped pole, now used by barbers – red for blood and white for bandages). The Guild of Barber Surgeons continued for 200 years or so, in seeming harmony, but it appears that as time progressed the original agreement was not being adhered to, and perhaps also, surgeons began to think better of themselves.

From the Milnes-Walker book, it would seem that there were three phases of relationship between barbers and surgeons (Dobson and Milnes Walker 1979). The Company of Barbers is referred to at the earliest in 1308 (page 9) (Dobson and Milnes Walker 1979). It was probably in existence prior to that, and more a religious organisation than related to trade. In 1376 the Barbers complained to the Mayor of London about unskilled individuals who were practicing surgery - these individuals were unskilled and untrained and came from outside London every day to practice (Burnby