DOCTORS, BUREAUCRATS, AND PUBLIC HEALTH IN FRANCE
1888-1902
Martha L. Hildreth
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MODERN EUROPEAN HISTORY

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Martha L. Hildreth
To my parents, Leroy and Ila Hildreth
PREFACE

In preparing my Ph.D. dissertation for publication I have taken the opportunity to make some revisions. Most are only grammatical; however, I have reorganized and (I hope) clarified some material. No new material has been added thus the bibliography is somewhat out of date having been compiled in 1982. I have taken the liberty of adding some footnotes which refer the reader to my own more recent work where appropriate.

I would like to acknowledge the invaluable help in manuscript preparation given to me by the Text Processing Center and the Department of Mathematics, University of Nevada, Reno. Text preparation costs were supported in part by the Center for Advanced Studies, College of Arts and Science, University of Nevada, Reno. In the preparation of the tables I was generously assisted by Charles Wetherell of the Laboratory for Historical Research, University of California Riverside. In the course of research I received vital help from the staff of the Archives de la Santé publique, Paris.

During the original preparation of the dissertation, and in the months since, a number of people have read and made helpful comments upon the manuscript. I would like to thank Ken Barkin, Patricia O’Brien, Alan Mitchell, George Weisz, and most particularly, Irwin Wall.
During various stages of my work on this manuscript my family has been a steadfast source of support. I would like to acknowledge the help given to me by my parents and the moral support of my sister, Margaret Rhyne, during the long months of research. Lastly, my husband, Bruce Blackadar, has been an ever patient source of support during my more recent revisions of the manuscript. I thank him for his help in proof reading and in formatting the manuscript for printing on a computerized text processing system. Most of all I am grateful for his tolerance while I spent a good deal of a supposed vacation revising the text.

Reno, Nevada
November, 1986
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INTRODUCTION

The years 1888-1902 were a crucial period in the creation of a modern medical system in France. Scientific developments, demographic and political concerns sparked an unprecedented period of government action concerning medical care. The nature of the resulting legislation was largely determined by a new medical union movement, promoting the professional goals of private physicians. The effects of these developments were manifold. In this period doctors were given state support which allowed them to dominate medical care as they never had before. A variety of public health services were created and ultimately a basic public health law was passed. A national medical assistance program was created to bring medical care to the rural poor. Finally, a number of new medical institutions evolved, including dispensaries, disinfection services, sanatoriums and medical insurance. Although overshadowed in the standard histories of the Third Republic by the tumultuous political events of the period, the medical
developments of 1888-1902 received considerable attention from legislators, bureaucrats and intellectuals of the time. Moreover these medical developments would ultimately have a tremendous impact on the general population. As Eugen Weber has indicated, this period saw the transformation of a disparate, rural, French society into a more homogeneous nation. The medical developments of the era should be included along side the modernization of education and transportation in the constellation of changes which most affected people's everyday lives.¹

The medical care system which evolved in France during this period combined state services with a liberal, private profession in what has been aptly called the "hybridization" of medical care.² The hybrid medical system is of course typical of most modern, capitalist nations, where modern medicine has been accompanied by the professionalization of doctors and their dominance over the practice of medicine.

It is a popularly held notion that professionalization came about in the late nineteenth century as a result of the development and adoption by the medical profession of a unified and effective theory of disease, the germ theory.³ According to this viewpoint, established doctors were able to rally around the germ theory and use it to support their claims to dominate the practice of medicine and exclude unlicensed practitioners. Physicians' claims were backed by the modern state which began to become interested in improving the health of its citizens by promoting modern medical care. The state thus granted physicians an autonomous position in regulating their own profession and helped them to dominate
the whole medical care system. This explanation, however, does not suit the development of modern medicine in France. Some French doctors were professionalized about one hundred years earlier. In addition, the French state took a very active role in medical care as early as the late eighteenth century.  

According to Toby Gelfand and David M. Vess, by the end of the eighteenth century, French doctors had developed a very "modern" notion of the status of their occupation as a profession and had achieved some of the major qualities which most sociologists see as characteristic of a profession. Most importantly, they achieved control over medical education and through the law of March 10, 1803. Gelfand also argues that in the late eighteenth and early nineteenth centuries physicians achieved a unified theoretical basis of practice based upon the clinical model developed at the Paris hospitals; however, this contention is contradicted by several other works.

In contrast to Gelfand and Vess, the work of Jacques Léonard, Jean-Pierre Goubert, George Weisz and Matthew Ramsey on the social and economic status of French doctors in the nineteenth century has shown that the average French doctor lived and practiced in a condition which was far from the status of a professional in modern times. Léonard shows that the average doctor occupied a humble place among the French bourgeoisie through most of the nineteenth century. Léonard’s work, along with that of Weisz and Ramsey, indicates that doctors struggled economically, rarely enjoyed the medical confidence of their local society, and competed with a wide range of traditional
healers and practitioners. Ramsey found that in spite of the legislation of 1803, local officials actually protected illegal practitioners.

Léonard, Goubert, Weisz and Ramsey on one hand and Gelfand and Vess on the other might seem to be talking about two different worlds, and indeed they are. As a number of historians have pointed out, the societies of urban and rural France were worlds apart in the nineteenth century. According to Harvey Mitchell, in the late eighteenth century the French medical world was divided into two exclusive systems: traditional, unlicensed medicine on the one hand, which treated the health problems of rural society and the lower urban classes, and elite physicians on the other, who practiced among the urban bourgeoisie and aristocracy. Mitchell further points out that rather than attempting to destroy traditional medicine, the urban elites tended to believe that the two different kinds of medicine were appropriate for their respective worlds. This left licensed rural practitioners to struggle alone against illegal practitioners without much official support. Medical elites in the cities were not particularly concerned with sharing the benefits of professionalization with their more humble country brothers. In order to understand the professionalization process among French doctors it is crucial to make this distinction between the of urban, academic elites and the average private practitioner of the villages and quartiers.

In the case of French doctors, it is useful to think of professionalization as a concept which originated among the elite physicians in the late eighteenth and early nineteenth century, and then, only much later,
became a reality for the average practitioner. How to define the elites is not an easy task. Certainly they would include the members of the Faculty of Medicine and Academy of Medicine in Paris who also dominated the prestigious hospital posts in that city. Also they would include doctors in similar positions in the other faculties of medicine at Bordeaux and Montpellier. In the course of the nineteenth century, some other urban centers also developed medical establishments: Havre, Lyon, Reims, Rennes, Toulouse and Lille. Léonard has also found evidence that there was a group of rural elite doctors in the nineteenth century who achieved status through former academic positions, personal wealth, or bureaucratic posts. These elites enjoyed high prestige and wealth from their academic and bureaucratic positions and were able to attract a profitable clientele from among the haute-bourgeoisie. They did not have to struggle to lure clients away from popular practitioners such as bonesetters and urine readers. Their only competition was among themselves.

The mass of doctors envied the benefits enjoyed by the elites, recognized the benefits of professionalization and aspired to transform their positions into something more like that of the elites. The large number of average practitioners who attended the Medical Congress of 1845 clearly demonstrated these desires. Professional concepts were well known to the mass of practitioners, but until the last two decades of the century they were not able to translate these concepts into reality in their own practices. Until then private practitioners had made periodic and unsuccessful efforts to obtain a revision of the law of 1803
on the practice of medicine in order to increase the severity of the regulations against illegal practitioners and to give all *docteurs* a monopoly over medical practice in their own areas. 15

The extension of professional status to the lower orders of *docteurs* was greatly aided by the final achievement of a new law on the practice of medicine, passed in 1892. The 1892 law was passed in the midst of the bacteriological revolution; however, the relationship between the scientific developments and the attainment of professional status by the average practitioners was ambiguous. The connection between the establishment of germ theory and the effectiveness of medical techniques cannot be assumed. Neither can physicians be assumed to have welcomed many of the new techniques and practices with the germ theory implied. The role of medical effectiveness in professionalization must be examined more closely. Since René Dubois first raised the issue in 1959, several researchers have maintained that the apparent improvements in health as measured by increased life span, which took place in the nineteenth century, were the result primarily of improvements in diet and quite later in the century, the result of public health measures. The only medical development which may have affected general health before the latter part of the nineteenth century was vaccination against smallpox. 16 As Thomas McKeown has pointed out, this fact has been largely ignored in the traditional literature on the history of medicine which concentrates on scientific developments. Medical historians have made little investigation into when and how these developments actually were put into practice and whether they had any
beneficial effects on general health. 17

What effect did the bacteriological revolution have on medical practice? Léonard remarks that it was the work of Pasteur and Lister which began to improve the economic and social status of the mass of practitioners after 1885. Léonard is careful to note that the reputation of official medicine improved as a result of the overwhelming publicity which Pasteur and his theories received after 1885. He does not credit the actual practices of individual doctors as having much impact on health, although he does imply that some doctors may have had a positive impact on health through the massive outpouring of advisory literature which they began to produce for popular consumption in this era. 18 McKeown maintains that effective techniques in medical practice were not developed until the twentieth century. 19 The type of medical changes implied by the development of the germ theory were those which lay in the realm of public health rather than private practice. As this work will show, the governments and bureaucracy of the Third Republic became interested in promoting new public health policies and programs, but private practitioners opposed many of these plans as threats to their status as liberal professionals. Nevertheless, French doctors were able to exploit the favorable reputation created by the work of Pasteur and Lister as well as the health concerns of the state to promote their professional goals.

The relationship of physicians to the state and to society is of course critical in understanding the process of professionalization. Sociologists studying the professions have concentrated their analysis on
these issues. Talcott Parsons built his model of professionalization largely upon an analysis of the profession of medicine. Basically, he interpreted the phenomenon of the profession as arising from a structural need of society. The need, in the case of medicine, was for a body of workers who could be trusted to fulfill a specialized technical function which the layman cannot comprehend or perform. The social body, according to Parsons, confers a monopoly on this body of experts in return for which the profession assures high standards of application of technical expertise, devotion to the interests of society, and honorability. For Parsons, the interests of the patient are the functional norm which define the profession.

Jeffrey Berlant, who also builds his model on the profession of medicine, maintains, contrary to Parson, that "the dominant force defining the profession is the collective interest of physicians which may or may not benefit patients." Berlant further argues that traditionally the medical profession has defined health in terms of the individual; most of the profession has been indifferent or even hostile to many public health activities. Finally, Berlant believes that there is no fundamental distinction between the profession and the world of business. As a pay-for-service activity, the profession of medicine arose as part of the free market economy; it offers a service in exchange for a price, and the service is based upon an unwritten contract between buyer and seller. 20

In his work focusing on the modern medical profession, Eliot Freidson emphasizes the circumstances of medical practice as crucial in defining the nature of the profession itself. Freidson explains that
basically the practice of medicine is an encounter between two individuals, the doctor and the client. The doctor is oriented towards dealing with individual problems, not broader social concerns. In fact, Freidson argues that the profession attracts those individuals who like to avoid broad political and social issues. Thus it creates practitioners who are biased in favor of direct action in a private setting. In other words, the profession attracts those who seek autonomy; therefore the nature of the practice, the one-to-one encounter, is reinforced by the personal orientation of the individuals who are attracted to the profession. For Freidson, individualism is thus the dominant element in the profession; he writes, "contrary to Parson, I would suggest that the practitioner is particularistic not universalistic." 21

Freidson's other valuable insights include his realization that the connection to science is a key in explaining the rise of the profession of medicine. This connection allowed medicine to expand into terrain once held only by law and theology. He argues that as human welfare became secularized, the helping professions arose as service workers to the state. This general phenomenon has also been described by Christopher Lasch and Jacques Donzelot in relation to the history of the family. 22 Freidson concludes, "Medicine’s position today is akin to that of religion’s yesterday - it has an officially approved monopoly of the right to define health and to treat illness." 23

Freidson also points out the importance of the formation of a coherent or accepted ideology in enabling a profession to become both cohesive within itself and validated to the outside world. He sees the
rise of bacteriological medicine as the crucial event for the professionalization of medicine. Before this, according to Freidson, physicians were simply a "learned group aspiring toward monopoly."  

Finally, Freidson stresses the role of the state in professionalizing medicine. The practice of medicine, he points out, is a consulting profession. It depends upon public obedience to the principle that there is only one group with whom it should consult in the case of illness. The promotion of an ideology is an important factor in assuring such behavior; the role of the state is crucial in supporting and enforcing the ideology. In other words, rather than giving benediction to the monopoly created naturally out of the needs of society, as Parson would have it, the state works with the profession in creating the monopoly by adopting and enforcing the profession's ideology.

Unlike Berlant and Freidson who concentrate on medicine, Magali Sarfatti Larson analyzes professionalization as a general phenomenon. She draws a great deal on Freidson's insights, particularly his analysis of how a profession produces an ideology. However, Larson approaches the problem from the standpoint of the development of capitalism and the market system. Thus she sees professionalization "as a process by which producers of a special service sought to constitute and control a market for their expertise."  The result is a new kind of structural inequality in society and expertise becomes (along with property) a way of defining class. Special technical knowledge becomes a new "scarce resource."  Larson also has a new view of the origins of professional ideology which she sees as arising from a need to keep the
expertise surrounded with barriers so that it remains scarce.

According to Larson, the model or image of a profession was formed before it became commonplace in all of society, but the development of monopoly capitalism provided the means by which the ideology of professionalization could become extended to all sectors of the population. For Larson, the nature of the profession is determined by how its ideology is defined. The expertise is defined by the elites and gradually extended down to the lower ranks. Those at the bottom of the profession tend to adopt the ideas of the elites because such adoption secures their economic interest. Thus by adopting a professional definition of expertise they are also at the same time buying economic security.

Larson sees modern scientific and technological developments as playing the role of affirmation. In monopoly capitalism science and technology have promoted growth to a level where it is at least felt in terms of a rise in the average standard of living. Thus a wider sector of the population feels the effects of science and technology and has come to see it as "a permanent and indisputable system of cognitive and ideological validation." 27

For Larson, as for Freidson, the role of the state is crucial. In marked contradiction to Parson, Freidson and Larson see no inherent contradiction between state intervention and professional development. Larson points out that professions are not inherently anti-bureaucratic. She emphasizes that the traditional view of the relationship between the professions and bureaucracy derives from the Weberian model of
bureaucracy as rational and legal. In this traditional view, bureaucracy is seen as inherently antithetical to the supposedly autonomous, self-regulating professions. However, as Larson points out, in practice bureaucracy and the professions have come to depend upon one another and tend to seek an equilibrium in their relationship. Modern technobureaucracy, like the professions, relies on expertise as a supporting ideology. Thus the professions and bureaucracy reinforce each other. Professions provides the authority of the defined expertise, and the bureaucracy supplies regulations, laws, and support mechanisms to assure the professional monopoly.

This study constitutes an excellent test case for the theories of Parsons, Berlant, Freidson and Larson. While agreeing with Freidson that ideology is important in the professionalization process, I do not see the bacteriological revolution as playing the role he ascribes to it in the process of the professionalization of French physicians. While it is certainly true that the bacteriological revolution helped to change the attitude of the state and the public toward the medical profession, it does not seem to have been terribly important, internally, to professional ideology. The professional ideology was defined on much less explicit grounds. Rather than a coherent theory of practice, French physicians in this period developed an image of their social role which was the rallying point for broader professionalization. According to this image, the physician performed a critical social service for which he should receive respect, adequate financial compensation, and special status from the state. The image stressed individuality in practice, and encouraged the
physician to rely on his personal judgment. Finally, the image pictured medical care as a personal, private encounter between doctor and client, or doctor and family, which should be compensated for directly by the parties concerned on a fee for service basis.

This study supports Larson’s contention that professional concepts were formed early in the development of market capitalism by the profession’s elite, and were then extended to the lower orders of the profession during a later phase of economic development which included the growth of monopolies. The timing of these developments in France would tend to support Larson’s model, although it is not at all clear that the French economy was truly entering into a phase of monopoly capitalism in the late nineteenth century. It must also be stressed that the general practitioners who achieved their desired professional status in the late nineteenth century did not adopt a model of the profession identical to that created about one hundred years earlier by the profession’s elite. It was axiomatic to their movement that certain changes must be made in France’s medical system in order for the private practitioners to achieve their own version of professionalism.

As Berlant and Freidson have noted, the attitude of the profession toward the health reforms of the bacteriological revolution was ambiguous. While not at all reluctant to identify with the scientific advancements made by Pasteur, Lister and Koch, and with the work of active public health reformers such as Paul Brouardel and A.J. Martin, private practitioners nevertheless actively opposed many public health reforms. Certainly there is evidence to support Berlant and Freidson’s
contentions that this opposition was motivated by a conflicting vision of medical care, in other words, the physician's emphasis on treating the individual rather than society as a whole. Yet their opposition to public health did not mean that the private physicians completely rejected state intervention. In accordance with the insights of Freidson and Larson, the profession and the growing public assistance and public health bureaucracy sought to resolve their differences and establish an equilibrium. The lower orders of the medical profession had a model to follow in the elites of the profession who had achieved the successful co-existence of state intervention and private practice. The lower orders sought the same sort of harmony, but with less state intervention into doctor-patient relationships. They also sought state legislation to extend their monopoly over medical practice, to facilitate the collection of fees and to make it possible for private, licensed, medical practice to be established in parts of the nation which had previously been unable or unwilling to support it.

The average private practitioners had sought this sort of legislative support for several decades. In the 1880's the relationship between the state and private practitioners changed dramatically, making possible the realization of these goals. The change in the state's attitude occurred out of the political and social issues which seemed critical for the preservation of the Third Republic. And it changed because private practitioners were able to organize their own political lobbying force, distinct from that of the elites, to guide the concerns of the government into the directions which private physicians thought the future of
medical care should take. Jacques Donzelot has argued that the state of the Third Republic formed an alliance with private practitioners with the goal of transforming the family life of the lower classes in order to "moralize and normalize" it according to middle class norms. As Donzelot describes, by the 1920s French doctors had established a firm role for themselves as expert witnesses in court cases and in the social service network, where they defined acceptable and unacceptable behavior in individuals and described proper family relations. Besides coming to dominate the interventionist-helping professions, doctors also affected the structures of the medical care delivery system itself.

Theodore Zeldin has pointed out that the social reforms of the 1890s have been largely ignored by historians. The traditional view of the period is one of stalemate and stagnation. However, between 1888 and 1902 the Third Republic legislatures passed numerous pieces of social reform legislation. Three of these laws effected the medical system and are the subjects of this study: the 1892 Law on the Practice of Medicine (Loi Chevandier), the Medical Assistance Law of 1893, and the 1902 Public Health Law. The reform period began with a burst of social legislation in the period 1892-1893 which dealt with working conditions among factory workers in general and limitation on work hours for women and children, as well as the medical issues of professional practice, medical assistance and public health. The reform movement was also responsible for the Méline Tariff, the 1898 Law on mutual aid societies and the 1898 Law on employer responsibility for work accidents. Zeldin states that the reform movement of this period
failed, but this is not altogether correct. It is true that no dramatic transformation of society took place, but as Zeldin himself notes, this was never the aim of most of the reformers involved. 33

The goals of the reformers of the period must be understood by an examination of the ideology of solidarism. As J.E.S. Hayward has pointed out, solidarism made it possible for legislators and bureaucrats of diverse political viewpoints to unite to initiate social reform under the Third Republic. 34 Solidarism is principally known as the ideology of the radical party after about 1895; its primary exponent was the radical leader who became prime minister in that year, Léon Bourgeois. Bourgeois took a very active role in medical issues and was Minister of the Interior when the Medical Practice Law and the Medical Assistance Law were drawn up in that ministry. Bourgeois was also the co-founder of the Permanent Anti-Tuberculosis Committee. In spite of the crucial role of Bourgeois and other radicals, solidarist ideology and medical reform appealed to members of a wide political spectrum. Solidarist slogans were expressed by progressives like Raymond Poincaré, opportunists like Jules Siegfried, moderates like Jules Méline and independent socialists like Alexandre Millerand. Its diverse appeal can be explained by its diverse origins, which included the thought of Louis Blanc, Proudhon, and Joseph de Maistre. 35

Solidarists were unified by the perception that in order to endure the Third Republic had to find a third way between socialism and laissez-faire capitalism. 36 The development of solidarist reform in 1888-1902 must be understood in light of two major threats facing the
ruling middle class elite: populationism and socialism. These two problems were intrinsically linked in the minds of the ruling elite and their efforts to counteract them inspired the medical reform legislation. Republicans were shaken by the strikes and Boulangist agitation of the period 1888-1893, and by the success of the socialists in the municipal elections of 1892 and in the legislative elections of 1893. These developments forced a general recognition of the need for social reform. Further, the distress of the rural population due to the agricultural crises of the period help to diminish faith in economic liberalism. At the same time, the Ralliement threatened to create a conservative ideology of reform which would capitalize on the unrest of the lower classes. The solidarist solution was to develop an ideology of reform that was "opposed equally to liberal economism, Marxist collectivism, Catholic corporatism and anarchist syndicalism." 37 The aim of solidarism was to achieve, in the words of Léon Bourgeois, "social peace through justice." 38

Solidarist reform was also inspired by the scientific developments of the late nineteenth century which seemed to hold out renewed hope for social progress. Solidarism consciously rejected Spencer's social Darwinism and sought active solutions for what Durkheim called cultural anomie brought about by the loss of traditional social structures based upon family and church. Solidarism stressed the view that the individual and society were organically linked by obligatory duties toward one another. Rather than independence, the goal of the government was to acknowledge the interdependence of all of its citizens and
to lead, or even force, its citizens to carry out their obligations to one another. Thus state assistance or at least mutual cooperation should replace voluntary charity in aiding the unfortunate.

At bottom, the goals of solidarism were profoundly conservative in that they intended to make no fundamental change in either the economic or social systems. Solidarism was essentially a program to make the peasants and working class more like the bourgeoisie. As Jean Jaurès noted in his comments on the solidarist backed Mélène Tariff, the reforms of the 1890s amounted to a slightly different rendition of Guizot's solution for the distress of the lower classes, "Enrichissez-vous." 39 The popular philosopher, Izoulet, explained that the goal of solidarist was to "prevent the crowd from overthrowing the elite, while yet admitting the crowd 'loyally and cordially into the state.'" 40 Solidarists were by no means seeking to equalize all members of society, and they had no desire to abolish private property or to attack capitalism. Rather they sought to improve the chances of working class families for a better life within the capitalist system by providing education, minimum wages, regulation of working hours, and limitations on the work of women and children. They also sought certain guarantees against the worst disasters which formerly devastated French families of the lower orders: illness, unemployment, work accidents, and old age. 41

Populationist anxiety was an equally important element of solidarist reforms. By 1888, French elites had worked themselves into a frenzied fear that the end of French society was in sight because of the low
reproductive rates of the population. In reality the population was never in real danger of disappearing and was actually continuing to grow in the late nineteenth century (5.4% between 1881 and 1911). 42 The anxieties over population resulted from the comparison of France, Germany and Britain for it was clear that the French were reproducing themselves at nowhere near the rate of their neighbors.

An important aspect of French populationism was concern over specific internal trends. By the 1890s it was apparent that the urban population was growing at the expense of the rural. 43 To the Republican elites this meant that the source of its troubles, the working class, was increasing in numbers, while the source of much of its support, the peasantry, was diminishing. 44 This could only mean the growth of socialism at the expense of radicals, progressives, and moderates. Thus the population question and the social question were inherently linked. There was a direct connection between such seemingly diverse projects as the Mélino Tariff of 1892 and the Medical Assistance Law of 1893: both were part of solidarist efforts to preserve the peasantry.

There were of course marked differences among the various proponents of solidarist principles. Left-wing radicals, radical-socialists, and independent socialists advocated serious state interventionism supported by a progressive income tax. Most radicals also desired an income tax but supported a more limited reform program which provided for some state intervention but which put more faith in social mutualism. Mutualism amounted to a sort of corporatism where employers, with some state encouragement, would help workers create
insurance societies and pension programs. Progressives and moderates generally backed radical-solidarist reforms but balked on the income tax, successfully blocking it. Nevertheless, much of the solidarist program was successfully enacted. Populationist concerns were used to push through the Medical Assistance Law of 1893, a law which was recognized at the time as a monument to solidarist ideology. These solidarist notions also entered into the arguments in favor of the 1892 Law on the Practice of Medicine as well as the 1902 Public Health Law. These medical reforms were issues which could unify radicals, moderates, progressives and even some socialists.

Solidarism and its political and populationist antecedents explain the intense interest of the French state, in the period 1888-1902, in the general issue of medical reform. The nature of that medical reform was determined by private practitioners themselves, acting through a professional Union movement which developed close ties and great influence with the governments of the Third Republic.

Although they did not hesitate to use solidarist and populationist arguments in favor of the reforms they desired, private medical practitioners had a very negative view of state interventionism and mutualism. The issue of state activism was one which separated the mass of general practitioners from the medical elites. The elites had benefited from the status offered by state positions and had promoted the state’s role in medicine. But in the opinion of general practitioners, medical bureaucracy needed to be greatly modified. Rather than aspiring to government positions, most physicians wanted to see the practice of medicine
separated from the status of *fonctionnaire*. Therefore, the suddenly renewed interest which the state took in medical matters in the late 1880s was both a boon and a threat to practitioners in the physicians’ Union movement. The Union’s goal was to harness state concern to their professional interest while raising barriers to state control over the medical system. They demanded state action which would protect and extend private practice while actively opposing the creation of a central bureaucracy to oversee public health and medical assistance, and working to reduce the role of hospitals and dispensaries in medical care. Thus the success of private practitioners in these areas meant the spread of liberal, private, market medicine at the expense of state-sponsored care and private pre-paid care.

As Jacques Léonard and others have pointed out, the Third Republic saw the rise of a large number of individual doctors to political prominence, a position they had not enjoyed in great numbers under the July Monarchy or Second Empire. 46 Certainly this was of great benefit to physicians in expanding professionalization. However, it was not the only factor or even the crucial factor. As subsequent chapters will show, although certain physician-deputies worked very hard to promote the professional goals of physicians, the mass of doctors found they could not rely on all of their colleagues in the legislature. Locally, activist doctors found they could not rely on the practitioner-representatives to the departmental councils either. Many of the politician-doctors came from the very medical elite which had profited from the tradition of state and medical elite alliance. Often these