Professional dominance? Encounters between physicians and patients in the first half of the 19th century under the Habsburg Monarchy

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ABSTRACT: In Vienna, the tradition of clinical teaching began with Anton de Haen's introduction of the newly established educational approach in the Buergerspital in 1754. In the second half of the 18th century, clinical teaching at medical faculties contributed to the shift of power relationships between doctors and patients. The medical gaze that the doctor and the patient directed towards each other regulated the patients' as well as the physicians' behavior in the setting of hospital medicine, but this does not mean that a wholesale transformation of the medical field took place. Patients were not mere passive objects of externally controlled processes but influential agents of medical process. Middle- and upper-class patients sought assistance from their family general practitioners even at the beginning of the 20th century, and the relationships between these family doctors and their patients were more equal. Up to the end of the 19th century, physician-patient contact often comprised traditional methods of consultation by letter, and physicians saw and treated their patients predominantly in the patient's homes. A doctor's medical authority was not solely based on his knowledge, skills, and reputation among colleagues at the medical faculty. As in the early modern tradition of doctor-patient encounters, patients continued to play the role of ultimate arbiter of the performativity of physicians.

KEYWORDS: physicians, patients, 19th century, clinical education, Habsburg monarchy, Marienbad.

1. Introduction (*)

Medicine underwent a major change in the late eighteenth and early nineteenth century. The clinic was established, alongside new medical schools as centres of education and scientific research based on the principles such as observation, physical examination, and comprehensive medical statistics. This process involved a change in the system: scientific, technological, and socio-cultural, associated with the concept of medicalisation of society and professionalisation of medicine. Medicalisation refers to the introduction of clinical medicine, whether or not it was «scientific», and the way in which it intersected with the lives of the population in situations that had to do with health; therefore, medicalisation was often accompanied by resistance[1]. A medical market was created, where university-educated physicians were privileged vis à vis all other persons performing medical activities (midwives, surgeons, unconventional healers)[2].

Michel Foucault's interpretation of medicalisation[3] defines it as the change in the state's approaches to the population, the relationship between power and the subject. Medicalisation is a process through which more and more aspects of human action and existence, human behaviour, and the body itself are incorporated into the expanding sphere of influence of professional medicine.

Ute Frevert significantly influenced the understanding of medicalisation within the German environment due to her work dedicated to the political aspects of disease between 1770-1880[4]. According to this German historian, medicalisation should be understood not only as a constant creation of a network through which were people subjected to the medical care of pro-

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1. Goubert, Jean-Pierre. The medicalization of French society at the end of the Ancien Régime. In: Stevenson, Lloyd, ed. A celebration of medical history. Baltimore and London: John Hopkins University Press; 1982, p. 170.
2. Jütte, Robert. The social construction of illness in the Early Modern period. In: Lachmund, Jens; Stollberg, Gunnar, ed. The social construction of illness. Stuttgart: Franz Steiner Verlag; 1992, pp. 32-35.
3. Foucault, Michel. The birth of the clinic (1966). London: Routledge; 2003, p. 24.
4. Frevert, Ute. Krankheit als politisches Problem 1770-1880. Soziale Unterschieden in Preussen zwischen medizinischer Polizei und staatlicher Sozialversicherung. Göttingen: Vandenhoeck & Rupprecht; 1984, p. 42.

fessionals, but it also influenced the population on the level of establishing norms and cultural signs that structured the mentality of social classes and established new forms of everyday life. By promoting the right and healthy forms of behaviour, doctors also identified practices that posed health risks and were marked as unacceptable for endangering the population. The connection between the state and medical professionals, which Frevert also emphasises, thus resonated in the complex transformation of culture. She argues that the promotion of this change began in the German lands already in the period of the late Enlightenment around 1770.

While the French and German scholarly communities have adopted the term medicalisation, together with the socially structuring context of the term, British medical history specialists have often been sceptical[5]. An exception was Roy Porter, who, however, differed from the term's continental understanding in his conception of medicalisation as a procedural phenomenon. According to Porter, medicalisation was rather a tool that was used by medical elites as an offensive device within a much broader programme of the neutralisation and suppression of rural culture[6]. The British historian includes medicalisation in his research as an outcome of the theoretical production of school medicine and scientific treatment concepts in the 18th century. Porter's conception of medicalisation is thus much more limited in its impact, and, in comparison with French or German historians, he does not understand medicalisation as a process that would successfully change the social normative. In many of his works, Porter has emphasised the continuing plurality of the medical field, which, despite the establishment of clearly defined and scientifically based methods of physical examinations, still gave patients many opportunities to find their own ways to regain their health independently of the official discourse[7].

Results of later analyses and case studies, which focused on the influence of medicalisation on real curative practices, raised many doubts. Sabine Sander, for example, studied the medicalisation process in Württemberg. Her

5. Particularly Digby, Anne. Making a medical living. Doctors and patients in the English market for medicine, 1720-1911, Cambridge University Press; 1994; Loudon, Irvin. Medical practitioners 1750-1850 and the period of medical reform in Britain. In: Wear, Andrew, ed. Medicine in society. Historical essays. Cambridge University Press; 1992, p. 245.
6. Porter, Roy. Doctor of society. Thomas Beddoes and the sick trade in Late-Enlightenment England. London–New York: Welcome Institute Series in History of Medicine; 1992, p. 105.
7. Porter, Dorothy; Porter, Roy. Patient's progress. Doctors and doctoring in Eighteenth-Century England, Cambridge University Press; 1989, p. 15.

analysis of the availability of medical care shows how numerous healthcare reforms in the early 19th century had almost no direct impact on the health of the populations they originally targeted[8]. In this sense, the author refers to a paradoxical deterioration in the availability of medical care, especially in rural areas. The inspirational and extensive publications by Johan Peter Frank expounding his ideas on the system of medical policy[9] influenced Central European rulers in their attempts to implement systematically governed and centralised medical care. However, most physicians concentrated their activities in the first half of the 19th century mainly on urban areas, which —together with the suppression of traditional folk healers— resulted in a *de facto* deterioration of the medical market, especially in terms of the availability of therapeutic help. Within this context, the question arises to what extent the progress of medicalisation contributed to the change of cultural determinants. Should we not understand the medicalisation process, associated with the period of absolutist Enlightenment, merely as a discursive mode that did not have a direct impact on everyday practice and the understanding of diseases and health issues? The German researcher Francisca Loetz, examining the impact of professionalisation and medicalisation on the medical field in Baden, concluded that the medicalisation process in this region could not be traced back to the period of the Enlightenment reforms of 1750-1770, but to a much later period, specifically 1830-1850[10].

Professionalisation encompasses a set of processes that began to significantly influence the forms of conducting medical activities at the turn of the 18th century. Originally taken from sociology[11], the term generally refers to a trend common to a number of disciplines that has four fundamental aspects: 1. the effort to establish a monopoly on the market; 2. the introduction of control of vocational training and access to the profession; 3. the formation of normative ways of acting, which corresponded to the customs and ethics of the profession; 4. promoting the autonomy of representatives of the pro-

8. Sander, Sabine. Die Bürokratisierung des Gesundheitswesens. Zur Problematik der «Modernisierung». In: Jahrbuch des Instituts für Geschichte der Medizin der Robert Bosch Stiftung.1987; 8, p. 210.
9. Frank, Johann; Peter. System einer vollständigen medicinischen Polizey, Vol. I – VI, Mannheim: C. F. Schwan 1784-1814.
10. Loetz, Francisca. Vom Kranken zum Patienten. «Medikalisierung» und medizinische Vergesellschaftung am Beispiel Badens 1750-1850. Stuttgart: Franz Steiner Verlag; 1993, p. 319.
11. Parry, Noel; Parry, José. The rise of the medical profession. A study of collective social mobility. London: Routledge; 1976.

fessional sphere, for example by creating joint associations promoting the interests of the whole community[12].

In the 19th century, physicians were still relatively far from suppressing all the other professions at the medical market. Due to their different historical traditions, surgeons and physicians were still separated from each other. Although surgery was taught at medical faculties and became part of the teaching of physicians, the social difference between the members of these two professions persisted. Physicians began to demand the monopolisation of power as early as the end of the 18th century[13]. A key argument in the fight against competing practices was the reference to the scientific nature of their activities. Action based on scientific evidence is still fundamental in the representation of modern medicine, and the basis of its claim to exclusive status within a range of different types of medical practices. However, as Robert Jütte has argued, until the beginning of the 20th century, the practical experience of a person offering his medical help was more crucial than academic degrees and a scientific career for paying patients when choosing a specific method of treatment and its provider[14].

The regulation of access for those interested in medical education and professional practice was inextricably linked with the issue of the monopolisation of professional medicine. As part of this process, not only the curricula of medical faculties were regulated, whether they concerned the education of doctors, surgeons, obstetricians, or midwives, but also the methods of licensing therapeutic practice. Authors drawing inspiration from French historiography tend to understand this process as a specific form of exercise of state power, promoting the medicalisation concept of the discipline of society. From this point of view, the legislative norms decreed and authorised by state bodies in the last third of the 18th century are considered a milestone.

German school of social history of medicine understands this process in a more structured way. Robert Jütte and Wolfgang Uwe Eckart date the major debates relating to the control of the acquisition of medical education in most countries to a later period, the fourth decade of the 19th century. They emphasise the efforts aimed at internal differentiation and the hierarchical

12. Eckart, Wolfgang Uwe; Jütte, Robert. Medizingeschichte. Eine Einführung. Köln – Weimar – Wien: Böhlau; 2007, p. 319.
13. Labisch, Alfons; Spree, Reinhard, ed. Medizinische Deutungsmacht im sozialen Wandel des 19. und frühen 20. Jahrhunderts. Bonn: Psychiatrie Verlag; 1989, pp. 181-194.
14. Eckart; Jütte, n. 12, p. 320.

separation of the group of professional physicians from other representatives performing medical procedures – especially early-stage physicians and midwives. The process of regulating the medical market was motivated by an effort to separate scientific medicine from practice-oriented professions. The aim of this endeavour was to reduce the number of university-educated physicians and redefine their status. Groups of physicians responded in this way to the growing number of practitioners operating at the medical market, which made an adequate income for all involved hard to achieve. One of the first organisations focused on the regulation and defence of the rights of the medical community was the Medical Society in Strasbourg, France, established in 1845, which was responsible for assessing medical offences; in the United States, the American Medical Association was founded in 1847; in Britain, the British Medical Chamber (General Medical Council) was created in 1858; similar institutions were established in the Habsburg monarchy much later. The Reich Act of 1891 allowed the establishment of medical chambers with compulsory membership for all physicians practising in the appropriate locality (except for military doctors and government employees). Consequently, a medical chamber was established for the first time in 1893 for the Moravian Margraviate based in Brno, and for Silesia in Opava; in 1894 the Medical Chamber for the Kingdom of Bohemia was established with its seat in Prague, divided into two sections —Czech and German. Until then, physicians associated voluntarily, for instance in the first such organisation associating Czech-speaking physicians —the Association of Czech Physicians, founded in 1862[15].

The process of professionalisation also includes the emergence of new symbolic ways of acting and the creation of performativity in connection with the physician's role in social interaction[16]. The emergence of the medical doctor's role as a representative of the medical profession helped to a large extent to complete and regulate internal relations of collegiality within the medical community, as well as promoting the acknowledgement of medical doctors by their clients. In committees, professional organisations, and during the education process itself, an awareness was created of a closed group defined by professional competencies. Together with Erving Goffman, we

15. Niklíček, Ladislav. Lékařské komory v Čechách na Moravě a ve Slezsku v letech 1893-1950. Brno: Institut pro další vzdělávání pracovníků ve zdravotnictví; 1991, pp. 38-42.
16. Within the context of Goffman's dramaturgical analysis of social roles; Goffman, Erving. The presentation of self in everyday life. New York: Doubleday Anchor Books; 1959, pp. 155-156.

could refer to this process as the formation and performativity of a new team. The strategies applied by professionals towards their clients —a negatively defined group of the population who did not possess a specialised education and expert knowledge— were an integral part of the socialisation process of a professional group of medical doctors. Foucault assumes that these adopted strategies were further disseminated throughout society. Normalizing gaze, when internalized becomes a mode of power for social control and imposes self-regulation[17]. The power-defined relationship between the group of professional experts and their lay clients defined and affected all future interactions between professionalised physicians and their patients.

As Roy Porter declared, it takes two to make a medical encounter —the sick person and the physician[18]. In this sense —from the patient's perspective— did the period of the evolution of medical gaze in medicine represent a paradigm shift, a breaking point between different periods? In Early Modern Era, patient-physician encounters were quite different from encounters in modern medical practice. Profession practice consisted in house calls and, according to Michael Stolberg, even a successful physician might attend no more than four patients a day in the eighteenth century. Thus, there was more opportunity for developing close personal encounters with the patients. Before 1850, only few renown authorities could afford to oblige their clients to visit them[19].

Patients could expect the physician to adapt his treatment to their individual needs and everyday lifestyle. Only physician who managed to convince his patient that he had investigated all individual determinants and subjective opinion about the state of the patient could gain his/her loyalty. Since the physician's professional prospects hinged on the patient's favour rather than his colleagues' esteem, medical practitioner had to accommodate his actions to the preferences of his clients. As Michael Stolberg has

17. Foucault, Michel. Discipline and Punish: The Birth of the Prison. New York: Random House; 1977, p. 184.
18. Porter, Roy. The Patient's View: Doing Medical History from below. Theory and Society. 1985; 2, p. 175; recent contribution to the history of the practical dimension of encounters with patients in Dinges, Martin; Jankrift, Kay Peter; Schelemilch, Sabine; Stolberg, Michael, ed. Medical Practice, 1600-1900. Physicians and Their Patients. Leiden, Boston: Brill; 2016.
19. Stolberg, Michael. Experiencing illness and the sick body in Early Modern Europe. New York: Palgrave Macmillan; 2011, p. 65

postulated, in the Early Modern Era the relationship between patients and physicians was much more symmetrical than it is today[20].

Given the changes in medical practice between 1750 and 1850, we shall enquire whether the changes of educational strategies at the medical faculties, influenced medical practice beyond the creation of clinical environment in which medical experts established much more dominant position. Did the changing paradigm of hospital medicine alternate the private practice of physicians regarding physician-patient relationship, too?[21] The analytical framework of this article is based on a comparative approach to the development of the professional performativity of physicians' roles in the Habsburg monarchy during the nineteenth century. For this purpose, two different types of occupations —clinicians and spa doctors— are compared in two case studies to assess the common strategies and differences in the performativity of the medical profession and the impact of the new types of power on changes in the relationships between patients and physicians. I follow the professional path of a physician/clinician and spa doctors with the purpose to define the contrast between discursive determinants of their performativity and authentic social practice they faced during the encounters with patients as well as reflect upon the economic success of their career.

2. Bedside medicine

During the period of bedside medicine, physicians commanded little corporate power, and therapeutic nihilism led patients to distrust the outcomes of professional treatment. Traditional[22] medical reasoning provided no evidence

20. Stolberg, n. 19, p. 68.
21. Even recent historiography, as Anne Hanley and Jessica Meyer demonstrate, tends to characterize the first half of nineteenth century as period of paradigm shift in this sense. By the mid-nineteenth century, the rise of hospital and laboratory-based medicine, according to Hanley and Meyer, had patient pushed into a supporting role, their illness experiences unfolding off-stage. Compare with: Hanley, Anne; Meyer, Jessica. Introduction: searching for the patient. In: Hanley, Anne; Meyer, Jessica, ed. Patient voices in Britain, 1840-1948. Manchester: Manchester University Pres; 2021, p. 2.
22. The term «traditional doctor» is used here as a category defined by Edward Shorter. Shorter distinguishes between the traditional, modern, and post-modern doctor, based on the evolution of different forms of social and therapeutic interactions between patients and doctors, see Shorter, Edward, Doctors and their patients. A social history, New Brunswick, London: Transaction Publishers, 1993, pp. 22-26.

for the belief that physical examination would be useful for a diagnosis of the patient's condition. Physicians omitted any kind of clinical investigation in the sense of examining the patient. On the other hand, they spent considerable time analysing patients' personal history and their own references to their medical condition. The relationship between the medical professional and the patient was therefore skewed in favour of the patient. Patients were responsible for providing their own personal medical histories, which were used by doctors to establish the diagnosis. Sick people would inform their doctors about when and how their condition had developed, what kind of symptoms they had observed and what treatment they had used. Patients would inform their physicians about their diet, everyday lifestyle, emotional state, and personal opinions on possible treatment. The best clinicians had to be the best listeners, doing their detective work in localising the source of the pathological condition not in the patients' bodies, but in their words[23]. The diagnostic process and the subsequent medical treatment were inseparably linked with the personality of the patient. And physicians were often asked about their opinion, recommendations, and prescription by letters —so their personal face-to-face interaction at the patient's bedside was not always needed.

Furthermore, bedside medicine was often practised in the households of the sick clients. The spatial dimension of medical practice was always a key element of the hierarchy. Invitation to a house, owned or rented by the patient's family, continued to place the physician in a subservient position. The temporary need for adaptation to the house rules led to another layer of hierarchy in the field of medical practice. Doctors were considered merely guests, not rulers governing the patient's body. According to their performance, they could either gain respect or —in the case of dissatisfaction— be mistrusted and neglected. Visiting physicians never held the dominant position that is guaranteed in the modern era as they attend the patients in hospitals, healthcare centres or private surgeries. The patient was the judge of the qualities of the practitioner, and the power of the patient could prevent the application of innovative —and potentially risky— ways of treatment. Most patients believed in the benefits of conventional medical remedies

23. Porter, Roy. The eighteenth Century. In: Conrad, Lawrence; Neve, Michael; Nutton, Vivian; Porter, Roy; Wear, Andrew, ed. The western medical tradition 800 BC to AD 1800, Cambridge University Press; 1995, p. 403; Stolberg, Michael. Homo patiens. Krankheits- und Körpererfahrung in der frühen Neuzeit. Köln, Weimar, Kiel: Böhlau Verlag; 2003, pp. 91-106.

and practices, and they pressured physicians to prescribe them despite the physicians' distrust in the efficacy of such remedies. Physicians were also dependent on their patients financially; therefore, they could not show off their intellectual superiority over their patients. The patronage model implied that client control was maximised, and the authority of the doctor minimised. The patient was seen as a conscious human totality[24]. The physician's task was to seek to grasp this whole and produce a treatment and regimen adapted to the maintenance of health. As N. D. Jewson defined, the patient's phenomenological account of his bodily state was essential to the process of medical examination and treatment[25]. The structure of traditional consultation was characterised by a history-taking, holistic approach. Thus, different competences were considered as key to a successful career. The advice given by the more skilled professional to a young practitioner regarding the success of a career in medicine at the end of the eighteenth century reflected the different realm of medical culture. In contrast with the modern era, the moral qualities of young adepts, as well as their physical appearance and ability to act in a trustworthy way were more important than the education and scientific knowledge achieved during their study at medical faculties[26]. The therapeutic nihilism of the traditional doctor and lay patients' disbelief in the doctor as a professional who understood the secrets of nature had cemented the form of their relationship well into to the nineteenth century.

Patients were empowered also by the fact that many consultations were conducted in written form. A lay description of symptoms followed with specific questions regarding the recommendation of the consulted physician was commonly used as a method of acquiring medical expert knowledge[27]. The practitioner depended in his conclusion on the patient's own opinion and characteristics.

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24. Jacyna, Stephen. Medicine in transformation 1800-1849. In: Bynum, W. F.; Hardy, Anne; Jacyna, Stephen; Lawrence, Christopher; Tansey, E. M., ed. The western medical tradition 1800 to 2000. Cambridge University Press; 2006, p. 54.
25. Jewson, N. D. Medical knowledge and the patronage system in 18th-Century England. Sociology. 1974; 8, 370.
26. Plocquet, Wilhelm Gottfried. Der Arzt, oder über die Ausbildung, die Studien, Pflichten, Sitten, und die Klugheit des Arztes. Tübingen; 1797, pp. 66-68.
27. Weston, Robert. Medical consulting by letter in France, 1665-1789, London: Routledge; 2013, pp. 105-106.

3. Hospital medicine

The distinction between bedside and hospital medicine was described by Ivan Waddington[28]. According to his analysis, the shift in the distribution of power from patients to physicians and thus the constitution of the modern medical regime occurred in the period of hospital medicine, defined by clinical education as an integral method of teaching at medical faculties. Of course, the paradigm shift could be traced in many different aspects of medical field. New forms of treatments and diagnosis came to replace bleeding and purging. Many of these changes, such as evolution in morbid anatomy, dissection, and pathology, were introduced via the establishment of the clinic, the cornerstone not only of education but also of scientific research. Principles of observation, physical examination and comprehensive medical statistics were three main outcomes of the existence of the clinic, and subsequently became founding elements of modern medicine. From the perspective of the development of the patient-doctor relationship, the existence of the clinic caused a significant shift of power. From now on, encounters between patients and physicians moved towards a hospital-based environment and had direct implications for the patient-doctor relationship[29]. In the reformed hospital environment, the doctor was now in a dominant position. His power over the patient enabled him to set the medical agenda in accordance with the priorities of scientific progress, which encouraged many different forms of diagnostic, analytical and therapeutic innovation. As Stephen Jacyna suggests «the patient ceased to be a person with whom the practitioner was obliged to negotiate and to whom he was obliged to defer and became a body upon which an ever-increasing repertoire of procedures might be performed»[30].

Ivan Waddington explains the shift of the hierarchy in the medical field by pointing to the differences in social status between doctors and medical students on the one hand and patients on the other. In the nineteenth century, hospital care was still considered a distinctive sign of poverty —only the poorest had to seek help in the hospitals, often seen as a place of last resort for prostitutes, beggars and the proletariat. As Waddington maintains, hospital consultants and students of medicine were traditionally recruited

28. Waddington, Ivan. The medical profession in the industrial revolution. Dublin: Gill and Macmillan; 1973, p. 215.
29. Foucault, n. 3, pp. 67-68.
30. Jacyna, n. 24, p. 55.

from the bourgeoisie. University educated and well-off hospital practitioners had to deal with uneducated, often illiterate patients. Inequalities in social, economic, and cultural capital[31] led to an attitude of superiority of physicians over their patients, who were not in the position to dispute or challenge the practitioners' decisions over their bodies. They were expected to follow the doctors' orders and submit to their will. If they started to protest, this would lead to their dismissal from institutional care, which was usually their last refuge[32].

This deficit of patient power turned the environment of the hospital into an ideal location for the introduction and application of new methods of examination and medical treatment. Patients were presented to the students not with the intention of enabling them to regain their health, rather they were specifically selected for experimental reasons, so that students would benefit from the vast spectrum of different illnesses and their stages. Social status and the fact that poor patients had to yield to the power of the doctor allowed the exposure of naked flesh and intimate parts of the human body to the gaze of the physician and often even to a large crowd of students, who were learning from a live demonstration of their tutors by the patient's bedside. In that regard, the personhood of the patient was reduced to a demonstrative body —a living phantom— serving a pedagogical purpose of medical faculties. The era of clinical medicine represented a transition from person-oriented to object-orientated medical cosmology. The role of patients was marginalised as they were ascribed the passive role of observed and treated bodies. The truth of disease was to be uncovered through the physician's examination.

4. The birth of clinical education in the Habsburg monarchy

In March 1791, the French revolutionary deputies introduced major changes to the medical legislation. All the old corporative regulations in the field of medical practice were dismantled, to be replaced with free market: «Everyone could, on payment of a fee, be not only his or her own physician, but provide medical services to whoever chose to consult them»[33]. This unimaginable

31. Bourdieu, Pierre. The logic of practice. Stanford: Stanford University Press; 1990, pp. 56-57.
32. Waddington, n. 28, p. 216.
33. Jacyna, n. 24, p. 39.

liberation removed all the obstacles in the medical field for anyone willing to offer a little medical advice or treatment to any interested customer. Nevertheless, changes on the medical market posed a threat of future disaster.

During the War of the First Coalition against the French First Republic between 1792 and 1797, the French army needed to take care of the health of its members. Learning from the outcomes of the first battles, the leading politicians of the republic soon realised that suitable treatment of the wounded soldiers, their crushed bones and shattered limbs was not only beneficial for the soldiers themselves but also crucial for the very future of the political system that they had established and fought for. Out of 2700 skilled medical officers in service in 1793, almost 1000 had fallen by the spring of 1794. Thus, the need for skilled medical practitioners, in particular surgeons, soon became of utmost thus began[34].

A new system of medical education this began to emerge in 1794. The first new schools of medical education were established in Paris, Montpellier, and Strasbourg in 1795. One of the authors of the reform, Antoine-François de Fourcroy, defined the new principles of schooling with the following motto —«reading little, seeing and doing much»— this was to be the basis of a new teaching. The main element of the new system was the clinic, where candidates of medicine learned the three main principles which became the trademark of the new era, the first of which was detailed observation of the patient during their stay in hospital. Thus, as Michel Foucault put it, the age of the medical gaze began[35]. This entailed using all possible kinds of physical examinations. Following Foucault's argument, we can describe the second principle as the opening of human bodies. Every pathological state of human organs was traced after the patient's death to the level of tissues, with the purpose of locating the illness and its consequences in the human flesh. Finally, thorough medical statistics were established to define the efficacy of the applied form of treatment. The old tradition of distinction and division between the education of surgeons (focused on practical treatment and intervention into the human body) and physicians (more theory-based education with a holistic approach to treatment) was changed to a single comprehensive system for all doctors.

34. Ramsey, Matthew. Professional and popular medicine in France, 1770-1830: The social world of medical practice. Cambridge University Press; 1988, pp. 75-76.
35. Foucault, n. 3, p. XIV.

However, clinical education as an integral part of the training of young physicians and surgeons is even older. In the Habsburg monarchy, the shift from theoretical to practical medical education began in the year 1744. Military conflict with Prussia, Bavaria and other states created a great need for changes in the process of physicians' and surgeons' education. As defined by the court law from 1 May 1744, at all medical faculties in the Habsburg monarchy new posts of professor for clinic education and medical practice were to be established. Practice-oriented clinical teaching offered students a new dimension of education in which they had to personally examine, diagnose, and treat their living patients for the first time. The real foundations of the new teaching method were later built on the background of this legislation.

The origins of clinical teaching in the Habsburg monarchy could be traced to Herman Boerhaave's (1668-1738) activities in Leiden, where he established clinical education in two six-bedroom wards in St. Cecilia's hospital. By 1714 Boerhaave was appointed as a professor of clinical medicine. His students Gerhard van Swieten (1700-1772) and Anton de Haen (1704-1776) then introduced clinical education in the Habsburg monarchy. In 1745, Van Swieten became the personal physician, medical innovator and adviser of the Holy Roman Empress Maria Theresa, and as such later called his Dutch colleague Anton de Haen from The Hague. In 1754 De Haen became head of medical clinic and introduced education by the bedside of patients in the Vienna district hospital.

Students of the Vienna medical faculty gathered for clinical education at 8 a.m. Haen led them towards the patient's bed and described the symptoms of the patient. Afterwards all the students were invited to perform an independent medical examination on the patient by themselves, and each was then to later whisper their opinion about the condition, diagnosis, and recommended treatment of the given patient to the ears of Anton de Haen. At the end of each session, the professor pronounced the actual diagnosis aloud, and concluded the bedside clinical education. The teaching procedure was followed by surgery hours for poor patients from the public. Medical students observed the process of medical diagnosis directly from their teacher, learned the practical aspect of therapeutic prescription and participated in the creation of special journals documenting patient's history of illness. De Haen also involved the students in research activities involving experiments on animals or with medical herbs given in small doses as a remedy for incurable diseases. One of the experiments was highly influential for

later medical practice. De Haen introduced the systematic measurement of the patient's body temperature at his clinic. He accumulated impressive statistical data involving both healthy and ill female and male bodies, and this practice became an indispensable element of the modern approach to medical diagnosis and treatment.

Clinical education by the bedside as practiced at the medical faculty in Vienna provided an inspiration for other parts of the Habsburg monarchy. In Prague, this new method of teaching was partially introduced in 1769 by Thaddäus Bayer, when he started giving practical lectures at the Military Hospital in Prague. Clinical education itself was later held from the year 1778[36]. The head of the new clinical ward, Professor Josef Plenčič (1751-1785), began to teach future medical doctors in one room consisting of eight clinical beds in the hospital of the Merciful Brothers order in Prague. The hospital was located conveniently near the Karolinum, the main auditorium for medical faculty students. Since the hospital was owned by the clerical order, the expenses of the new clinical room were covered by the state allowance of 50 guldens, which was rather an honorary acknowledgment than cost-covering funding. Thus, to compensate for the expenditures of the Merciful Brothers, Josef Plenčič took soon into his personal care another fifty beds in the hospital and used them for the further education of his growing number of students[37]. Unfortunately, the gradually expanding number of patients caused the order of Merciful Brothers in Prague serious financial troubles. They sought help from Empress Maria Theresa, and after a thorough analysis of the hospital's financial records from the previous 10 years, she finally acknowledged the need for financial support of 8000 guldens, delivered by the government in 1779. The radical new principle of education amazed the state representatives as well as the members of the land government, and by 1783 they included practical clinical education at the Merciful Brothers hospital into the surgeons' curriculum.

With the enthronement of Emperor Joseph II in 1780, a revolutionary era of innovation in the healthcare began in the Habsburg monarchy. Certainly, no other state in Europe would fulfil the conclusions of Michel Foucault's historical analysis regarding bio-politics more literally. In the first year of his rule on 24 May 1781, Joseph II declared directives to future hospitals and

36. Later named Na Františku Hospital.
37. Held, Johann Theobald. Kurze Geschichte der Heilanstalt der Barmherzigen Brüder in Prag. Nebst Rückblicken auf Entstehung. Prag: Bohumil Haase; 1823, p. 61.

other medical facilities. Based on these legislative foundations, in every land of the Habsburg monarchy medical institutions known as General Hospitals were established, providing care for the poor and lonely, ill and diseased members of the population. Joseph II declared obstetric wards (usually linked with orphanages) and asylums an indispensable part of the future institutional healthcare network. The costs of the crucial infrastructure were covered by the dissolution of religious orders, deemed of little benefit for society —and the subsequent sale of their real estate and movable items. In Vienna, the construction of New General Hospital began immediately, and it was opened on 16 August 1784 as the largest hospital in Europe, providing 2000 beds for patients in 111 rooms, including gardens and courtyards for leisure activities. According to the internal rules, all patients were to have their own bed at their disposal, which represented an important improvement in comparison with many other facilities. Before his coronation, Joseph II had travelled across the monarchy and even beyond its borders in disguise as count Falkenstein, with the intention of studying the quality of health care in different facilities. For example, he was horrified by the fact that in Hôtel-Dieu in Paris was in 1777 often one bed was shared by three different patients[38]. Other General Hospitals in Habsburg monarchy were opened later —in Brno by 1786, Olomouc in 1787 and Linz in 1787 and the last in Prague by 1791.

The bio-political directives were not limited to a new infrastructure. Revolutionary changes were also incorporated into the educational system. Clinical teaching, which had been adopted as a beneficial inspiration from the Low Countries, was officially included in the curriculum of medical doctors and surgeons in the new regulations of the faculties of medicine after 1786. According to these regulations, medical and surgery students devoted themselves to practical medical and surgical teaching at the patient's bedside. In Prague, teaching continued in the Merciful Brothers hospital, but after 1791 the clinical ward of the medical faculty moved to the new Prague General Hospital, where «clinical beds» for 12 patients, 6 male and 6 female, were set aside for this purpose. In the case of medical students, clinical teaching initially took up their fourth year of study, later the last two years of their academic curriculum.

38. Lesky, Erna. Meilensteine der Wiener Medizin: Große Aerzte Oesterreichs in drei Jahrhunderten. Wien: Maudrich; 1981, p. 31.

Clinical teaching at Prague General Hospital was led by Johann Anton Sebald (1753-1799), a professor of pathology and clinical practice. Sebald did not participate in teaching at any other department of the faculty, so he could devote himself fully to the clinical demonstration. To further stimulate the independence of the clinical ward, the general hospital itself was run by a different senior consultant, and the university therefore gained a specific space to develop the practical dimension of teaching.

The General Hospital in Prague, located in the rebuilt Educational Institute for Noble Women, was lavishly financially subsidised since the time of Joseph II. The hospital had 300 beds for patients and a further 34 for staff, the corridors were wide and bright, used by the sick for walks, while only the highly placed windows resembled a prison building in the visitor's mind. By placing the windows so high up, the proto-medic Thaddäus Bayer wanted to prevent suicide attempts by the patients.

Clinical education by professor Sebald took place at the clinic every day from 9 to 10 a.m. The number of participating clinical students was small, so each of them had the opportunity to see the patient well, and the patients themselves were specifically chosen for the purpose of diagnostic and therapeutic demonstrations from other wards of the General Hospital. How important was the changing environment —spatial disposition for the relationships between future doctors and their patients? Clinical education is usually described as a turning point, as it divided the doctor-patient relationship into two different paradigms —the paradigms of bedside medicine and hospital medicine.

However, was clinical teaching essential for changing the physician's relationship with the patients, or should we understand the so-called French revolution in medicine merely as a change in the epistemology of medical science, which influenced the formation of the internal professional habitus[39] relating to the acquisition of expert knowledge while the relation of medical doctors towards their patients remained unchanged?

39. The notion of habitus is defined as a system of durable, transposable dispositions, as principles which generate and organise practices and representations, Bourdieu, Pierre. The Logic of Practice. Stanford: Stanford University Press; 1990, p. 53.

5. Johann Theobald Held

Only an analysis of actual medical practice could shed light on the formation and potential changes of the relationships between physicians and patients. For this purpose, I focus on the careers of two influential medical doctors from the first half of the 19th century — Johann Theobald Held (1770-1851) and Carl Joseph Heidler (1792-1866). Johann Theobald Held became a dominant figure of the Prague medical scene, as proven by the fact that he was repeatedly elected Dean of the Prague medical faculty. Heidler was one of the founders of the tradition of spa treatment in Marienbad. Both were graduates of the Prague medical faculty.

The difference between the status of physicians in the Habsburg monarchy also depended on the prestige of the medical faculty that a physician graduated from. The General Health Regulations of Maria Theresa stipulated that the applicants to the posts of municipal and regional physician had to submit a diploma proving their education. If the candidates for the post of physician graduated from the Vienna and Prague medical faculties, they were hired on the spot with only one additional condition: a proof of their previous practice. On the contrary, graduates of faculties other than these two centres of science had to pass an additional exam that proved the skills and knowledge acquired at «regional» universities[40]. Thus, within the internal hierarchy of the medical field, at the beginning of their careers, Held and Heidler were endowed with the same level of professional prestige.

At the time when Held was studying at the medical faculty, the number of medical graduates was very low. During the 18th century, the number of medical students rarely exceeded ten per year, the number of newly enrolled students of medicine in Prague oscillated between zero and ten, in some years no new student entered the medical faculty; also, the numbers of graduates ranged between zero and six to eight. At the time of the Josephine reforms of the educational system in the medical field, the numbers of all students of the medical faculty began to approach two dozen, and in the 1790s the faculty of medicine had as many students in a single year as the previous total for several decades. During the years 1700-1753, 114 medical doctors graduated from the Faculty of Medicine in Prague (an annual average of 2

40. Sinkulová, Ludmila. Lékaři, stát a zdraví lidu. Z historie zdravotní služby v českých zemích. Praha: Státní zdravotnické nakladatelství; 1959, p. 33.

graduates), while in the years 1784-1815 this increased to 215. The annual average of graduated physicians increased to seven[41].

This fact also influenced the method of teaching. Johann Theobald Held described the beginnings of clinical teaching in Prague in his memoirs. He viewed the low number of students present at the patient's bedside in the clinic as unequivocally positive; this way each student had the opportunity to be literally in touch with the patients and make use of this possibility to develop his diagnostic potential, as Held remarked:

> «A small clinic is destined to enable the birth of observational talent by students and helps to mediate the experience of his future profession; but too many patients in large clinics could lead to carelessness, detachment and confusion»[42].

Held considered large clinics, in this case especially the Vienna clinic, to have a negative influence, because the basic principle of clinical teaching —the possibility of gaining practical knowledge and skills— could not be accomplished. In the clinical teaching of renowned contemporary authorities, such as Johann Petr Frank (1745-1821)[43] in Vienna or Christoph Wilhelm Hufeland (1762-1836)[44] in Berlin, students were actually failing to profit due to the growing number of attendees:

> «How many of them can besiege the bed without bothering the patient? How many can take the pulse at once? The patient would have to have nerves of steel for his heart rate to remain unchanged as he was approached by twenty, fifty or a hundred listeners! Poor patients who have recently [1840-1844] had

41. Hlaváčková, Ludmila. Lékařská fakulta 1802-1889. In: Kavka, František; Petráň, Josef, ed. Dějiny univerzity Karlovy III, Praha: Karolinum; 1997, pp. 58-59.
42. Květ, Jindřich; Tinková, Daniela- ed. Jan Theobald Held. Fakta a poznámky k mému budoucímu nekrologu. Vzpomínky pražského lékaře na léta 1770-1799. Praha: Academia; 2017, pp. 357-359.
43. Johann Peter Frank (1745-1821), German physician and hygienist, renowned as a reformer and councillor to many authorities – the King of England, Emperor of Austria, where he was employed in 1795 as a director of the General Hospital in Vienna and sanitary service reformer, later served at the Russian court as a personal physician to the tsar. His comprehensive nine-volume treatise A Complete System of Medical Policy (System einer vollständigen medicinischen Polizey) influenced the reforms of medical care, prevention and hygienic standards in Central Europe.
44. In 1798 Christoph Wilhelm Hufeland (1762-1836), a renowned German physician, gained the position of director of the medical college and state medical affairs at the hospital Charité in Berlin, and thanks to his writings became one of the most influential medical authorities in Central Europe.

> to submit to the method of auscultation and palpation! Where is the decorum in the hospital when every woman has to undress in the presence of thirty or forty young idiots and let them tap with their fingers on her back?»[45].

Thus, according to Held, clinical teaching worked only if the number of students receiving education at the clinic remained low; when dozens of young students attended a clinical demonstration at the same time, the value of the new, progressive form of education was lost. Although the fundamental influence of clinics on embodying theoretical knowledge in the practical activities of physicians cannot be denied, clinics were not able to prepare future physicians for the reality of their own encounters with patients after graduation.

Held finished his studies in 1797, and due to his relatively poor origins, he had to choose a career strategy that would soon bring him financial security. The first meeting with a paying patient after graduation clearly foreshadowed the reality of his future profession for the young doctor. The first paying patient was an old midwife who paid him a tolar for curing her of inflammation of the liver:

> «It is hard to describe how I felt with this way of rewarding! Until then, I had been used to receiving my scholarship in exchange for examination certificates, and I had always received fees for lessons in larger monthly amounts. Even today, I am horrified when I think that even very meritorious men with many years of experience in the profession receive their reward after a finished consultation as a tip into their hands —like sextons, acolytes, tinkers, chimney sweepers or apprentices and others! Does this look like the authority and prestige of a self-sacrificing medical profession?»[46].

During his studies, Johann Theobald Held received several scholarships, earning income by performing in musical ensembles, and benefited financially from teaching in prominent and wealthy families. His annual income as a medical student ranged from 800 to 900 guldens. Upon launching his own professional career, however, he encountered a harsh reality. Held became truly horrified at the meagre level of low his real income as a medical doctor.

Lacking a family tradition and connections in the medical profession, the young physician could not use them to his advantage, unlike some of his

45. Květ; Tinková, n. 42, p. 359.
46. Květ; Tinková, n. 42, p. 393.

colleagues. Thus, only three career options were left for him in Prague —the first was to become an assistant to one of Prague's renowned professors at the medical faculty and gradually build his own reputation, so that in the future he could replace his mentor at his post. Another career path to was to become a family or personal physician in an influential noble or upper-class family and thus achieve a higher symbolic social status, which attracted new clients and secured a sufficient income. The third —and probably most difficult— career path at the time was to apply for a post in one of the hospitals in Prague. At first, Held hoped for a career as a family doctor, but despite the general popularity he later enjoyed in the social circles of Prague society, at the very beginning of his career he had not succeeded. His financial situation forced him to look for a prompt solution, so he applied for the post of hospital doctor at the Merciful Brothers Hospital in Prague, which he was granted. Within two years, he became hospital's head physician, and he worked there for more than three decades, supplementing his income with private practice. His total income, combining his private practice with the post of hospital doctor in the hospital at the Merciful Brothers, was 248 guldens, so as a practising doctor in Prague he could only obtain one third of the income which he had earned during his studies.

From his encounters with his patients Held quickly concluded that it was not his level of scientific knowledge and practical competence that could persuade patients to demand his services. He gradually came to understand that the fundamental dimension of medical activity was, above all, the ability to deal with patients:

> «After a few years, I gained the experience that people need to be treated as musical instruments to communicate more easily. Man has to hit the Turkish drum quite differently than the tambourine»[47].

Through clinical education, physicians acquired contemporary techniques of body examination, diagnostic methods, and treatment. Nevertheless, completely different strategies were needed in the development of a career, such as the ability to establish personal relationships with influential and wealthy female clients, sometimes going as far as having a sexual relationship with them:

47. Květ; Tinková, n. 43, p. 467.

> «It is remarkable that the vast majority of young doctors gain fame and reputation through the fairer sex; either the young physicians use their personal charm to influence female clients, or they are really «performing a cure» [with intimate attentions to their female patients]. Some of them marry into a respected or wealthy family from the countryside. Although I, myself, became known exclusively for my service in the hospital and service for the poor, since I did not want to become a servant to an already famous colleague, nor did I seek marriage, I often became convinced that many of my colleagues based their existential happiness on the path of prostitution»[48].

In fact, Held's private practice also benefited from the philanthropic support of a woman —countess Therese Kinsky (1768-1822). At the beginning of his career, the countess donated several hundred guldens each year for the sake of the poor, which the young doctor used to pay expenses for the treatment of poor patients. Remarkably, financial support was used not only to cover Held's personal service to patients, but in addition, together with every prescription he gave the patient a few guldens to cover the cost of the medical remedies in the pharmacy. By subsidising the clientele, he gradually gained a reputation and paying clients. By 1806, he already estimated the number of his clients whom he continuously cared for at 333. They included the bourgeois as well as members of aristocracy. Later, between 1806 and 1814, Held became a senior consultant at the clinic of the medical faculty in the Prague General Hospital, and as such also one of the leading representatives of the supposedly changing paradigm in the medical field, centred on practical clinical education. As a prominent figure among Prague medical doctors, Held became the Dean of the medical faculty in Prague in 1817-1819 and 1822-1825.

Based on Waddington's conclusions, we would suppose that the professional status of Johann Theobald Held influenced his attitude towards his patients. The patient and the practitioner formed a new dichotomy of the empowered and powerless. Differentiation in the social status of doctors and patients in hospitals and the fact that poor patients had to yield to the doctors' disciplining power led to the disbalance in their relationship. The patient's personhood was reduced to that of a demonstration model, serving a pedagogical purpose. Unfortunately, we do not have any casebooks or practical journals from Held's practice in hospital, but, based on the analy-

48. Květ; Tinková, n. 43, p. 477.

sis of his correspondence with patients from his private practice, we may conclude that the discourse of his letters was completely different. There is no sign of physicians' supremacy over the patients, on the contrary, as Held declared in his own words: «A practitioner, an extraordinarily busy doctor, is [through his practice] slowly evolving either into a slick gentleman or a crude, impolite servant»[49].

Held defined two opposite poles of the possible role of a physician, but it is almost impossible to find traces of professional authority between references about the performance as a crude servant and a socially (not scientifically) appreciated gentleman. The paradigmatic revolution in education undoubtedly changed the way in which physicians perceived the body. But did clinical practice in the first half of the 19th century change the interaction between physicians and their clients? On the contrary, it was the doctors who had to adapt their actions to the reality of the medical market. Physicians clearly worried about being belittled by their wealthy paying patients. Maybe it is precisely their experience of supremacy over their patients in the hospitals that made them feel —albeit slowly and in an incomplete way— that they should not have the need to behave in such a way with their clientele, because it was an affront to their dignity. After all, this fact is reflected not only in personal memoirs, but also in the discourse of the publications intended for preparing future practitioners for the performance of their profession.

6. Discursive performativity of the physician's encounters with patients

Georg Christian Gottlieb von Wedekind, a German physician, Freemason and revolutionary, published a book in 1789 entitled *On the Physician's Behaviour, How to Find Healing by Gaining the Patient's Confidence and Belief*[50]. Based on his own experience, Wedekind formulated advice for students and future medical practitioners on how to treat patients during medical examinations and consultations. According to the author, the first condition for establishing a successful relationship was to gain the patients

49. Květ; Tinková, n. 42, p. 463.
50. Wedekind, Georg Christian Gottlieb. Über das Betragen des Arztes, den Heilungsweg durch Gewinnung des Zutrauens und durch Überredung des Kranken: Zwei Vorlesungen. Mainz: Kurfürstliche Privlilegierte Buchdruckerei; 1789.

confidence, because only thanks mutual respect and trust guaranteed that patients would subsequently put their life into the hands of doctors.

Instead of a clearly-defined hierarchical position, determined by the acquired education and university degree — symbolic capital gained in the process of acquiring professional skills, Wedekind's treatise defines the position of doctors as variable, fluent and unstable[51]. At the end of the 18th century, the position of the therapist in relation to the patient was defined more by the specific conditions of mutual personal interactions than by the symbolic transfer of power, an objectified symbolic and cultural capital declared by the state authority or corporate power of the professional field.

Wedekind pointed out the lack of training for handling of patients in the preparation of future physicians:

> «The teaching of medicine at universities is reduced to pathology, therapy and some practical tasks. However, how a doctor should behave in front of their clients and at the patient's bedside as a person and representative of the state, and the way in which way he can gain the trust of his audience, is taught by no one at any university or clinic»[52].

Every young practitioner had to learn how to master interactions with patients only after he had launched his private practice or when he became involved in clinical treatment after graduating from university.

According to the German author, the position of physicians in relation to patients was quite uncertain. In the days before the professionalisation of medicine, physicians were much more dependent on a good reputation than on their certified knowledge and skills. At a time when the «patronage system» prevailed in the doctor-patient relationship, it was therefore important to treat patients in accordance with their own ideas and expectations. For this reason, Wedekind advised novice physicians to gain the trust of patients by convincing the patients that the therapy prescribed by the doctor, as well as the interpretation of the disease, were flawless.

To achieve this result, it was not necessary to persuade patients with scientific arguments; to gain the patient's trust, the doctor had to provide

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51. See also Lachmund, Jens; Stollberg, Gunnar. The doctor, his audience, and the meaning of illness: The drama of medical practice in the late 18th and early 19th Centuries. In: The social construction of illness. Stuttgart: Franz Steiner Verlag; 1992, p. 53.
52. Wedekind, Georg Christian Gottlieb. Vom Zutrauen in zwei medizinischen Vorlesungen. Mainz: Joseph von Hagen; 1791, pp. V-VI.

truthful information, or at least information corresponding to the patient's vision of his or her own ailments. The social prestige and popularity of medical staff did not always depend on their level of education or therapeutic ability. In fact, «bad» doctors often enjoyed the favour of patients, while scientifically educated therapists had trouble earning a living. Physicians had to pay particular attention to developing their eloquence that would enable them to convince patients and explain the nature of their illness and subsequent treatment without constant reference to new scientific knowledge. In the period of traditional «bedside» medicine, disease was a much more variable and unstable phenomenon than we might expect. Nosology did not yet prevail; on the contrary, diseases were defined in a mutual interaction between the physician and patients, they were constructed in the process of their diagnosis and subsequently culturally interpreted by the patients being treated without direct dependence on the objective scientific world of medical terminology.

Wedekind depicted the virtual line between educated physicians and their uninformed patients as follows:

> «Physicians tend to get carried away by the urge to inform their audience in terms of scientific pathology related to the case. They respond in this way to the requests of patients, asking doctors for an explanation of the nature of their disease and its symptoms, and provide them with a scientific explanation. I do not recommend that. The patient needs to know only the name of the disease, to be aware how to take the medication and take his condition into account through applying appropriate dietary measures. He cannot understand pathology and professional therapeutic discourse anyway»[53].

It seems that Wedekind's advice was valid in the period of bedside medicine, and it was the hospital environment that caused the shift of paradigm.

However, we can find similar descriptions of the doctor-patient relationship long after the Ackerknecht's French revolution in medicine supposedly occurred. In 1850, the Czech physician Jan Melichar summarised his personal experience on the pages of the Slovan magazine:

> «He [the physician] stood alone by the bed for the first time. The sick patient in front of him, simultaneously full of despair and confidence in medical help, and in front of him a young man with a head full of all sorts of scientific

53. Wedekind, n. 52, pp. 45-46.

> theories, but emptiness in the place where he should have known how to help [the patient] to the recipe of life and out of the darkness, where he [the physician] had been driven by his choice of occupation»[54].

Both Wedekind's and Melichar's characterisations of the interaction between patients and doctors seem to provide a proof of a certain shift in the paradigm. The impossibility of clarifying scientific principles to ignorant patients led to a differentiation within the medical field, and the creation of a group of «insiders» whose effort was to have a positive impact on their surroundings, using the acquired knowledge, but not to try to disseminate the knowledge to laypersons. Here we observe a clear formation of the contours of the future relationship between physicians and patients —a relationship based no longer on interdependence on each other, but on the incommensurable relationship to medical knowledge, from which physicians drew their future power and status.

Wedekind's characterisation of medical practice at the turn of the 18th and 19th centuries is described through a terminology used in theatrical plays. Patients are referred to as the «audience» and medical success is measured by «praise from the audience». Similarly, the doctor's meeting with the patient is described as a performance in front of the patient, the goal of which was, as in a theatre play, to convince the patient of the reality and truth of the doctor's efforts.

The steady increase in hospital care contributed to the spread of asymmetrical power relations between doctors and patients to the broader society, but this does not mean a wholesale transformation of the medical field. Recent research in this field has concluded that from the seventeenth to the nineteenth centuries the number of lower- and middle-class patients increased. The social composition began to change at the beginning of eighteenth century and in the early nineteenth century in urban areas, where, in German-speaking countries, members of low-wage workers, and even domestic servants and farm day-labourers made up a considerable percentage of the physicians' clientele. In rural regions the practice of traditional folk-healers or barber surgeons continued to flourish. However, the frequency of contacts with physicians was still considerably higher for aristocrats and clients from the educated and well-off bourgeoisie than from the other

54. Melichar, Jan. Žádoucí opravy v lékařství. In: Slovan. Časopis věnovaný politickým a vůbec veřejným záležitostem slovanským, zvláště českým; 1850, p. 1321.

classes, thus patients of more secure social standing consulted a physician considerably often than lower class patients[55].

Middle and upper-class patients sought help from their families' general practitioners even at the beginning of the twentieth century, and the relationships between these family doctors and their patients were more equal. Fee-paying patients could still choose their doctors according to their own preferences. In that sense, they were masters of their own destiny. Although they had formed a consciousness of belonging to a unique professional group, physicians could not benefit from their symbolic capital defined only by their knowledge and education, and the role they played in front of their patients was defined by the contours of traditional (pre-clinical) relationships towards patients. Nineteenth-century medical market offered opportunities a more patient-cantered orientation of medical practice and consultation, particularly in the profession of spa doctors. Thus, in the following part we will follow the career trajectory of Carl Joseph Heidler.

7. Carl Joseph Heidler

Carl Jospeh Heidler's medical practice is a typical example of success in traditional career development. He completed his education as a doctor of medicine and a master of obstetrics in 1818 at the medical faculty of the University of Prague. After graduating, Heidler intended to start a private practice in Prague. However, the letters addressed to his father show that the expected success was impossible for him to achieve, and the young doctor's financial situation was dire[56]. Therefore, he immediately decided to stake everything on an uncertain card —the pursuit of a career as a spa doctor in the emerging, but at that time still insignificant locality of Marienbad (Mariánské Lázně). By 1818, on the recommendation of the governor of Bohemia, František count Kolowrat-Liebsteinsky (1771-1861), Heidler joined the service of the Teplá monastery, and by 1820 became an official spa doctor with a private clientele. He remained in Marienbad uninterruptedly

55. Baschin, Marion; Dietrich-Daum, Elisabeth; Ritzmann, Iris. Doctors and Their Patients in the Seventeenth to Nineteenth Centuries. In: Dinges, Martin; Jankrift, Kay Peter; Schlegelmilch, Sabine; Stolberg, Michael, ed. Medical Practice, 1600-1900. Physicians and Their Patients. Leiden – Boston: Brill; 2016, p. 60.

56. State Regional Archive in Plzeň. Family archive Heidler, i. n. 3, letter dated 2.5.1818.

until 1857. Heidler followed on from the activities of his predecessor, the physician Johann Josef Nehr (1752-1820). His close association with the abbot of the Premonstratensian monastery in Teplá and the founder of the spa tradition in Marienbad, Carl Caspar Reitenberger (1779-1860), facilitated his later success. Heidler was invited to Marienbad at a time when intensive preparations, which later enabled the foundation of the spa structure, were underway. At that time Reitenberger, the abbot of the Teplá monastery, ordered the drainage of the swamps surrounding the mineral springs and the construction of facilities for accommodation, therapy and leisure of the spa guests.

The young doctor soon realised that his future career would depend on the prosperity of Marienbad. Together with Abbot Carl Caspar Reitenberger, he formed a synchronised team which brought Marienbad to world fame. Reitenberger was a visionary who was willing to make substantial investments, and Heidler provided the symbolic capital and expertise of a physician, which was necessary to disseminate the spa's reputation in the medical field. Heidler began to practice in Marienbad in March 1818, earning 200 guldens per year in addition to his private practice[57], and immediately felt the obligation to fulfil a crucial task; at the very beginning, what was needed was neither the diagnostic examination of patients nor the prescription of their cures, but an analysis of the qualities of the local mineral water springs, and the establishment of the usefulness of the local peat mud used for therapy.

Reitenberger considered Heidler as an employee, but also as a partner. Their mutual correspondence shows that he tried to involve Heidler in the development of the spa. Carl Heidler was continually encouraged by Reitenberger to disseminate information about the new spa locality, for example sending correspondence to all the medical authorities in Europe with whom Heidler came into contact or writing and publishing popular and scientific treatises promoting the healing effects of Marienbad mineral water. Heidler published his first significant contribution —*The Mineral Waters of Marienbad* in 1819[58], and other books were soon to follow[59].

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57. State Regional Archive in Plzeň. Family archive Heidler, i. n. 4, letter dated 11.3.1818.
58. Heidler, Carl Joseph. Ueber die Gas-Bäder in Marienbad: nebst einer skizzirten Beschreibung dieses Curortes. Wien: Wimmer; 1819.
59. Heidler, Carl Joseph. Marienbad nach eigenen bisherigen Beobachtungen und Ansichten. Wien: Carl Gerold; 1822; Heidler, Carl Joseph. Kurze Nachrichten aus Marienbad. Eger: J. Kobrtsch; 1823; Heidler, Carl Joseph. Allgemeine Regeln für Kranke bei dem Gebrauche von Marienbad. Prag: Schönfeldschen Buchdruckerei; 1826.

Heidler recognised the potential of the spa location almost immediately, and in 1818 invested all his funds in the construction of a spa hotel. The young physician acquired the necessary capital of 1500 guldens from his father. Following Reitenberger's request and subsequent inspections by government representatives, the provincial governor František, count of Kolowrat-Liebsteinsky issued a decree on 6 November 1818 granting to Marienbad an official licence as a public spa.

The clientele of Marienbad grew remarkably, as did the commitments of Carl Heidler. What were his encounters with patients like? Between October and May Heidler engaged in correspondence with clients. The spa season was limited to a five-month period between May and September, used by incoming guests for a visit to the spa of up to four weeks. Instead of the diagnostic procedures learned in the process of clinical teaching, Heidler was in contact with his patients for most of the year via consulting correspondence, a genre in which the roles of patients and physicians followed the traditional forms of interaction. While correspondence was often limited to ordering accommodation or booking services for a future visit in the spa, Heidler, as a spa doctor, often adopted a servant-like position in the correspondence, fulfilling the wishes of the wealthy and noble clientele[60]. Very often, through correspondence to Heidler, clients ordered a shipment of mineral water, consulted him on accommodation options, or announced their intention to undergo therapy recommended by their personal physicians[61]. The scope of activities of a spa doctor thus corresponded with the traditional model of the doctor-patient relationship, and was essentially unaffected by the revolutionary changes that took place due to the introduction of clinical teaching.

Heidler later also held the position of senior consultant in Marienbad's general hospital established in 1826, where he treated poor patients. However, his clientele consisted mainly of wealthy visitors to the spa, with whom he was in direct contact for four weeks, and in an indirect, written contact for the rest of the year. Instead of diagnostic examinations, he provided clients with advice on suitable accommodation, recommended the use of specific springs and had mineral water sent to their home addresses. His therapeutic and publishing activities contributed to the dissemination of the reputation

60. State Regional Archive in Plzeň. Family archive Heidler, i. n. 12, letter dated 7.4.1827.
61. State Regional Archive in Plzeň. Family archive Heidler, i. n. 12, letter dated 23.4.1845.

of West Bohemian spas, which in the first half of the 19th century attracted the interest of the wealthy bourgeoisie and aristocracy.

The rise of his personal fame guaranteed Heidler a career based on the traditional habitus of the medical profession. Confirmation of his professional and economic success came in 1844, when Heidler bought the Staré Sedliště chateau and manor as a family residence, where he assembled an extensive balneological and medical library. Ultimately, after being ennobled in 1857, his social ascent in economic terms was complemented by objectified symbolic capital in the form of a noble title, wealth, and a chateau estate.

Comparing Carl Joseph Heidler's financial situation with that of Johann Theobald Held's, we are struck by the difference in the economic success of both career paths. The «success» of Johann Theobald Held's career can be very precisely defined in terms of wealth at the peak of his professional life in 1838. At that time Held was very ill, and in anticipation of his approaching death wrote his last will, including a record of his fortune. In 1831 he sold his library, which he considered his greatest source of wealth. By 1838 he had already sold all his real estate, and so he was left only with cash. He listed 100 guldens necessary to cover the costs of his own funeral, and he also left a small amount maintenance money for his maids and a donation of 78 guldens to a public school for orphans. Thus, in 1838 all his financial capital consisted of 178 guldens, demonstrating that even a successful career of a medical doctor was not sufficient to climb up the social ladder or, rather, to establish oneself firmly within its upper echelons[62]. While the intersection of a private practice with a post at a prestigious clinical ward of a General Hospital in one of the two medical centres of the Habsburg monarchy almost led to the financial collapse of Johann Theobald Held, the career of traditional medical consultant in a spa gave to Carl Joseph Heidler a chance of economic and social advancement.

8. Conclusion

It is indisputable that physicians defined and distinguished themselves in the first half of the 19th century in relation to patients through their acquired

62. Květ, Jindřich, ed. Jan Theobald Held. Dopisy bratrovi a jiným. Praha: Topičova edice; 1939, pp. 151-154.

knowledge, education and belonging to an exclusive professional group. However, the awareness of belonging to a superior professional group was shared mostly within the group itself and transferred through discursive corpus of expert texts. By contrast, in consulting and therapeutic practice, doctors had long held a much less dominant position over patients. Professional success on the medical market still depended on the popularity and level of acceptance by patients, in a way almost identical to the situation in the 18th century. How else are we to explain that perhaps the most profitable situation within the medical profession was that of spa doctors, whose activities were predominantly based on the traditions of consulting correspondence?

The unwritten rules of medical encounters with patients obliged the doctor to cultivate the personal qualities needed to engage successfully in interactions with clients. A physician without empathy and distinctive interpersonal skills would not have much chance of succeeding at the medical market and would not be seen as a helpful practitioner. A doctor's medical authority was based not only on his skills, since another decisive factor was his charisma, judged by the patient in the role of an ultimate arbiter.

The continuation of the traditional relationship could be expressed in economic determinants. During the period of bedside medicine, the doctor relied on direct payment for his services from the patient. Although in the regime of hospital medicine, patronage was dispensed within the career structure of medical profession, almost every physician was dependent also on a private practice, where the old rules of the traditional medical market remained in place.

Were patients in the physician-patient encounter generally submissive or did they rather behave like clients demanding a service? Recent analysis of German-speaking regions proved that physician-patient relationship evolved very slowly. In the seventeenth century the patients' opinion about prescribed therapy was seen as important feedback, but the independent judgment could also be observed in the patients' approach to the therapeutic recommendations of nineteenth-century medical doctors[63]. Physician-patient contact up until the nineteenth century consisted of communication about

63. Neuner, Stephanie; Nolte, Karen. Medical bedside training and healthcare for the poor in the Würzburg and Göttingen policlinics in the First Half of the Nineteenth Century. In: Dinges, Martin; Jankrift, Kay Peter; Schlegelmilch, Sabine; Stolberg, Michael, ed. Medical practice, 1600-1900. Physicians and their patients. Leiden-Boston: Brill; 2016, pp. 225-226.

complaints and negotiation of possible medication and the views of physicians often met with the scepticism on the part of the patients[64].

The analysis of records documenting physicians-patients encounters indicates that most physicians noted how patients rated their condition or the therapy, whether they followed doctor's recommendations, prescriptions or they rejected them and found other help. Conversation between physician and patient remained a key part of the treatment. Wherever possible, patients chose doctors at the medical market. Their choice depended often on predetermined conditions such as geographic accessibility of a physician, or his position within the structure of a local medical market that involved, for example, a responsibility of a publicly appointed doctor to attend the poor. Treating one family member often led to further request of services and provided a good basis for extending the services to wider social circles of the patients, particularly the patient's relatives[65].

The traditional paradigm of the physician-doctor relationship shifted much later. Institutional and scientific specialisation preceded the specialisation of practice, laboratory medicine legitimised physicians' diagnostic and preventive expertise, focused on public hygiene, degeneracy and decline, highlighting the power of the laboratory medicine to cure disease[66]. Similarly, the introduction of health insurance in the Habsburg monarchy in 1888 enabled the broader participation of the lower classes in the consumption of the services of the professional medical market, but the influence on physicians' private practice grow very slowly and visible changes of the medical market in this sense could be traced after the World War I[67]. Although most of the medical authorities fought against the future backbone of medical market, compulsory health insurance granted them independence from the patients' direct payments. Only then could authority be derived from the physician's status within the framework of the institutional system, clinical

64. Ritzmann, Iris. Vertrauen als Mittel zur Patientenbindung. Historische Blicke auf eine ärztlicge Strategie. In: Baer, Josette; Rother, Wolfgang. Basel: Schwabe; 2015, pp. 149-150.
65. Baschin, Marion; Dietrich-Daum, Elisabeth; Ritzmann, Iris. Doctors and their patients in the Seventeenth to Nineteenth Centuries. In: Dinges, Martin; Jankrift, Kay Peter; Schlegelmilch, Sabine; Stolberg, Michael, ed. Medical practice, 1600-1900. Physicians and their patients. Leiden-Boston: Brill; 2016, p. 62.
66. Berge, Ann La; Feingold, Mordechai eds. French medical culture in the Nineteenth Century, Amsterdam-Atlanta: G A; 1994, p. 10.
67. Wagner-Braun, Margarete. Zur Bedeutung berufsständischer Krankenkassen innerhalb der privaten Krankenversicherung in Deutschland bis zum Zweiten Weltkrieg. Stuttgart: Franz Steiner Verlag; 2002, pp. 162-163.

or academic. The patient no longer had a role in constructing or judging the authority of medical staff. The steady increase in hospital care by the turn of the twentieth century contributed to the spread of the asymmetrical power relationships between doctors and patients. The continuation of the process of medical specialisation and the discourse of scientific progress meant that the codes typical of the hospital environment spread to the whole society. ▮