In another sense, too, structural changes within society helped formulate this problem framework. Earlier chapters have already touched on how the emergence of separate ‘professions’ of doctors and pharmacists in the middle of the century marked a significant stage in the establishment of altered perceptions of opium. Professional medical control was to be one of the most important motives behind the new way of looking at the drug. In the second half of the nineteenth century the growing self-confidence and organization of the medical and pharmaceutical professions made a significant contribution to the altered perceptions of opium use. This came about in two ways. There was an increased concern about the availability of the drug, and that this should be in the hands of professional men. It began with the agitation leading to the 1868 Pharmacy Act and continued at the end of the century with the struggle to bring chlorodyne under pharmaceutical supervision. But there was also concern at the way the drug was used and about the medical control of its users, exemplified in the establishment of the particular problem of hypodermic morphine use and the outlining of disease theories of addiction, which are discussed in Chapters 12 and 13. In the 1850s and 1860s, however, the professional bodies concentrated on the availability of opium, not its use; the result was the 1868 Act.

Pharmaceutical organization in the 1850s and 1860s

In the 1850s and 1860s, there were moves to establish the medical and pharmaceutical professions as separate, self-regulating bodies. These had as their corollary the restriction of the open sales of poisons, opium among them, and their reservation to one or other of the emergent medical professions. Separate professional organizations were emerging in many areas at this time; the consolidation of professional accountants, surveyors and actuaries, for instance, was underpinned by the expansion of the middle class in industrial society. A massive growth in their incomes increased the market for specialist services.1 This process began in 1841 with the establishment of the Pharmaceutical Society, which began to organize a separate profession out of already existing chemists and druggists, and those members of the Society of Apothecaries whose main concern was dispensing. The newly organized pharmaceutical chemists were granted a charter of incorporation in 1843. They were at first a minority body, with a membership of only 2,500 in the 1850s out of around twenty-five thousand drug sellers. The long-term aim, however, was to organize a close-knit body, membership of which would be essential in order to practise and use the title of chemist. The society laid most stress on educational qualifications as the key-stone of professional status; there was a strong desire to restrict trade in the interests of its members. 2

Its initial objective was to limit the title of chemists to those who had passed its own examinations as well as gradually to raise the status and quality of chemists already in practice and eventually to achieve a monopoly of practice for its own members. These objectives were the main focus of activities in the 1850s and 1860s. They were partially fulfilled by the 1852 Pharmacy Act, which confirmed and extended powers already conferred by the Society's
charter of incorporation. It set up a register of pharmacists and limited the use of the title to persons already members of the Society, in business before the Act, or who had passed the Society's major examination. But the exclusive powers of trade which it had sought to obtain were rejected. They were incompatible with free-trade principles and no restriction was imposed on the carrying-on of a druggist's business. The Society had not yet fully established the principle of a professional monopoly. Nor had it yet established itself as the controlling body of the profession. In the late 1850s it opposed two Poison Bills introduced by the government, in 1857 and 1859. The Society wanted restriction of sale of poisons, but only on its own terms. The Bills, instead of giving the Pharmaceutical Society control of admission, proposed a system of licensing and examination under the control of a Board in which its members would be in a minority.

Rival professional organizations were also on the scene. The newly established General Medical Council, brought into being, along with the single list of medical practitioners, by the 1858 Medical Act, was equally anxious to secure the professional standing of the general practitioner, a newly developed section. In its early days the General Medical Council aimed to close professional ranks against unqualified outsiders and to fashion a profession far from the lowly tradesman and craftsman status of the apothecary and surgeon. It also aimed to include a wide range of functions under its own aegis. There was a sustained medical attempt to include pharmacy within the ambit of the medical profession, and a claim to legislate for pharmacy as well as for medicine. Surgeon-apothecaries had made a living by charging for drugs rather than for treatment, since the latter was not allowed by law, and many general practitioners continued, after 1858, to keep 'open shop' in order to dispense medicines. Before 1913, 90 per cent of all dispensing of doctors' prescriptions was still done by doctors themselves. In the 1850s and 1860s, therefore, medical claims to control pharmacy were not outrageous.

In 1863, a committee of the General Medical Council proposed a new medical act in which pharmacy would come under medical control. But another 'professional' body was also on the scene, and this complicated the issue. The United Society of Chemists and Druggists was founded in 1860-61 to represent non-members of the Pharmaceutical Society who were disgruntled about that body's apparent failure to organize the trade and to defend its interests. There was rivalry between it and the Pharmaceutical Society about who was to control the profession. This led to the introduction of competing Bills by the two organizations in 1864. The Pharmaceutical Society's 'Number One' Bill sought to assert its own control over entry. The United Society's 'Number Two' draft tried to secure the position of those who were not members of the Pharmaceutical Society. This Bill included provision for the restriction of the sale of poisons to qualified men, however defined.5

The Select Committee to which both Bills were referred recommended that, in the light of such fundamental disagreement over control of entry, neither draft should be proceeded with.6 Compromise between the two organizations finally gave the Pharmaceutical Society control (although the General Medical Council was still hoping to establish its own overall responsibility). The 1868 Pharmacy Act established a system of registration involving both major and minor examinations under its direction; the United Society dissolved soon after. The educational monopoly had effectively been established.

The 1868 Act also went some way to achieving the profession's other strategic objective. This was the restriction of the availability of drugs and poisons. The same series of inquiries and draft Bills which had brought pharmaceutical self-regulation also forwarded the parallel

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professional aim of control of the sale of drugs. The 1868 Act continued a process foreshadowed by the 1851 Arsenic Act, which had already restricted sales of the drug. It controlled fifteen selected poisons in a two-part schedule. Those in the first part, cyanide of potassium and ergot, for instance, could be sold only if the purchaser was known to the seller or to an intermediary known to both. A detailed entry was to be made in the poisons register. The container itself had to be clearly labelled `poison', with the name of the article and the name and address of the seller. Only these labelling restrictions applied to poisons in Part Two of the schedule .7

Opium and pharmaceutical organization

Those professing specialist status felt that their standing would be jeopardized if any unqualified person could sell drugs, or if any member of the general public could decide on his own medication and buy it openly. Opium as a widely used drug naturally came into the story at this point. Professional feeling, as expressed in the movement for control, complemented and paralleled the public health movement, where the presence of a large medical contingent has already been noted. For the 1860s, when the whole question of open sale had come to a head, was also the decade when the question of opium overdoses was drawing increased attention from these quarters. Sir John Simon, Medical Officer of the Privy Council, the main driving force in the public health movement since the demise of the General Board of Health, produced in his annual reports a condemnation of opium. In this he was aided by the reports from Drs Greenhow and Hunter already mentioned and by the advocacy of Professor Alfred Taylor. Taylor had argued for strict control over the retail sale of poisons, and especially opium, before a House of Lords committee in 1857; and in 1863, as part of Simon's annual report, he produced a detailed report on dispensing and sale. He put forward the professional point of view. Only qualified persons should sell poisons and their sale by `chandlers, grocers, oilmen, drapers, or small shopkeepers' should be prohibited. Taylor did, however, allow that some might be licensed to sell medicines used by poor consumers."

It was the combination of entwined professional and public health moves, of the class tensions which had emphasized lowerclass use of the drug, which brought opium's inclusion in the 1868 Act. What was categorized as `opium and all preparations of opium or of poppies' was eventually placed in Part Two of the poisons schedule. The proviso which included `strychnine and all poisonous vegetable alkaloids and their salts' in Part One appeared to cover morphine. It was not always interpreted in that way, and preparations of morphine were added to Part Two in 1869. But the decision over where opium was to go was not a straightforward one. The story of how and where this drug was included in the Act, just because of its importance in all areas of society at this time, showed up the weaknesses of the professional argument

Two factors combined to limit the amount of restriction placed on opium. The self-interest of the professional pharmacists was in. part responsible. While medical men, in particular those involved in the public health movement, were uniformly anxious. for stricter regulation of its sale, an objective consistent with their general professional objective of creating a monopoly of prescribing, the pharmacists thought differently. They were anxious to remove the sale of poisons from unqualified dealers, but did not want to restrict the sale of opium to the extent that their own trade in it would be affected. Humanitarianism clashed with professional self-interest. There was also the practical realization that opium, in the absence of orthodox medical care, did have a large part to play in the lives of the poor. Stringent restrictions on its sale would only
create an illicit market. The general shopkeeper would be as important as before and professional control would be undermined. These considerations affected the changing place of opium in the deliberations on restriction and the draft Bills of the 1850s and 1860s. Strict control of the drug was proposed in the 1857 Sale of Poisons Bill. Opium, along with twenty-two other drugs, was to be kept under lock and key, to be sold only to persons of full age in the presence of a witness known to both retailer and purchaser, or on production of an official certificate (signed by a clergyman, doctor or G.P.) stating that the poison might be safely supplied. Its sale was to be recorded by the chemist. Medical opinion favoured this type of restriction, and Professor Taylor argued strongly for it in front of the House of Lords Committee on the Bill.' Even he had to modify his views when faced with the realities of opiate consumption.

Recognizing the problem of small sales to working people, he conceded that the sale of pennyworths of laudanum should be allowed to continue, but only to adults, and on condition that the drug was drunk in the chemist's shop.

He had to admit that severe restriction was not practicable and that the drug was a special case. He, like the pharmacists, realized that `a smuggled sale might go on' if its open sale was suddenly curtailed. Other professional workers agreed, in particular the pharmacists, who had most to lose in professional terms from such an eventuality. Jacob Bell, president of the Pharmaceutical Society, thought that the 1857 Bill might help control opium sales, `but it would be almost impossible to carry it into effect in many country districts, where pennyworths of laudanum and opium are very often sold...' John Abraham and John Baker Edwards of the Liverpool Chemists' Association agreed. They were opposed to the scheduling of opium because they, like Taylor, believed that restriction would only produce a growth in illicit sales and the law would be impossible to enforce. Sales of the drug would remain with the back-street shopkeepers; opium would be sold, `as it is sold now, by a low class of dealer throughout the villages in the country in defiance of the law'.

Later drafts of the poison bill in the 1850s took this point. The version of 1859, for instance, proposed to exempt small quantities of opium and those dispensed on prescription from its requirements. Spencer Walpole who, as Home Secretary, was charged with introducing the Bill, explained the dual reason for this. `If you put a difficulty in the way of giving it in small quantities to persons who desire it, you may interfere inconveniently with these requirements as well as with the trade of the chemist.' Despite medical hostility to this limited concept of control - the Royal College of Physicians petitioned parliament urging that even small quantities of opium should be under the control of qualified people - it was generally accepted from this time onward that opium could not be rigidly controlled. The United Society's draft Bill of 1864, for instance, provided only that `opium, its extract, and laudanum' should be properly labelled.

Competing professional positions were shown at their clearest, however, in the struggle over the place of opium in the 1868 Pharmacy Act. Doctors and the public health men argued for further restrictions, while the pharmacists fought to limit control of the drug to a manageable level. The first draft of the Bill did provide for the regulation of opiate sales in Section 17, but only with labelling restrictions. By the time the measure was introduced in the Lords by Earl Granville on 19 May 1868, all mention of the drug had been dropped. No explanation of this was given at the time, but Elias Bremridge, the Pharmaceutical Society's Secretary, later told the Pharmacy Bill Committee of the General Medical Council that it had been dropped because of protests from within the profession - the promoters of the Bill received such strong representations from chemists residing principally in Cambridgeshire, Lincolnshire, and Norfolk, against interfering with their business - opium, as they stated, being one of their chief articles of
The passage of the Bill was therefore marked on the one hand by attempts to include the drug and even more severely to restrict its availability, on the other by pharmaceutical efforts to make regulation conform to their own professional interests. The medical profession used its political and parliamentary influence to this end. The Parliamentary Bills Committee of the British Medical Association meeting on 3 July came out strongly against the weak regulation of sale proposed by Section 17 and the ‘very imperfect schedule of poisons’. The General Medical Council was more explicit. After a meeting of its Pharmacy Bill Committee with representatives of the Pharmaceutical Society on 11 July it voiced strong medical feeling that self-medication with opiates must end -‘the Committee were of the opinion that the statement that regulations as to the sale of opium would interfere with the trade profits of druggists in certain parts of England, constituted the strongest ground for inserting opium in the list of poisons’.14

Robert Lowe, later both Chancellor of the Exchequer and Home Secretary under Gladstone, took up the medical point of view in the Commons. He pointed out what he saw as the prime motive for the drug’s non-appearance in the schedule : Perhaps because more profit is got out of the sale of this poison it is not proposed to deal with it.15 On 15 July, his amendment in committee added ‘opium and all preparations of Poppies’ to the Bill. This was later amended to opium and all preparations of opium or of poppies‘ by the Lords. Section 17 of the Bill in its final form provided for a two-part Schedule; poisons in the Second Part, including opium, were subject only to labelling restrictions. But Section 16 of the Act specifically excluded patent medicines, many opium-based, from its remit.

The Act was testimony to the force of professional strategies and to the conflict between medical and pharmaceutical interests. The controls it established on opium were marked by the contemporary belief in voluntary self-regulation and an absence of state intervention. The Privy Council Office had overall responsibility for the legislation and as such was the ancestor of the Home Office in present narcotics legislation; but real, power and control resided with the Pharmaceutical Society. Despite its limited nature, however, the Act did have an immediate and notable effect. So far as mortality can be measured from the inadequate Registrar General’s statistics, deaths from opium did indeed decline.16 The opium death rate fell from 6.4 per million population in 1868 to 4.5 per million in 1869. After a decade, however, the rate once again climbed to over 5 per million and remained at that level, sometimes higher, until the early 1900s (Table 3, p. 275). By the end of the century, the general opium death rate was at roughly the level it had been before 1868. The number of children dying from opium overdoses was, however, permanently reduced. Among the under-five group, the death rate declined dramatically from 20.5 per million population between 1863 and 1867, to 12.7 per million in 1871. It remained at that level until the 1880s, when a further decline to between 6 and 7 per million took place. The decline in laudanum fatalities was particularly marked. But this was paralleled by an increase in the adult death rate from opium.

The death rate among those aged thirty-five and over showed an absolute increase on pre-1868 levels by the end of the century (Table 4, p. 276). The Act’s effect on accidental and suicidal opiate deaths was also unremarkable. Although the accidental opiate death rate declined from its pre-restriction level of around 4 per million population, it remained until the 1890s at between 3 and 4 per million, not a notable decrease. Accidental poisons remained the major cause of opiate fatalities, at least in the published figures. They still provided over 70 per
The 1868 Pharmacy Act

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cent of the general opium rate in the late 1870s. The Act was also ineffective in discouraging opiate suicides. The suicide rate from opium showed little variation until the 1890s. It remained at between 1 and 2 per million population until the late 1880s. Other methods of suicide were always more widely used, as the pre-1868 figures show. But opium remained responsible for a large proportion of poison suicides, and was not decisively displaced (by carbolic acid) from the top of the list until the 1890s.

The Act was not completely ineffective; and it is perhaps surprising that it is possible to trace direct results in terms of the decline in general and child death rates. For the Act often operated in practice rather more laxly than even its framers had intended. Despite the reservation of opium to professional control, general sales did continue to a limited extent. The Pharmaceutical Society itself even advocated an interpretation of the Act which made this possible. `Preparations of opium' were distinguished from 'preparations containing opium'; only the former, defined as containing 1 per cent of opium or more, were included in the meaning of the Act." Paregoric was, for instance, thus excluded; laudanum, Battley's Solution and other preparations included. This compromise in 1869 prevented some of the more obvious abuses of the Act - shopkeepers had sold lumps of opium in boxes labelled 'opiate mass' and claimed that, as patent medicines, they were not subject to control." It satisfied trade interests and avoided the undermining of professional status which could have resulted from continuing open sales. Such sales did undoubtedly still proceed in some areas. Voluntary `policing' by the Pharmaceutical Society's inspection was insufficient to fulfil the Act's purposes. The inspectors were given no powers of entry or rights to inspect :business records or registers. At Ince in Lancashire, Emma Ashcroft, a patent-medicine vendor and drysalter, was prosecuted for selling laudanum in 1889 only after a child of nineteen months had died. She had been in business for twenty years."

As with much legislation, the way the 1868 Act operated in practice was rather different from original legislative intentions. In many respects it made little difference. Certainly customers who could afford medical attention and obtained their opium on prescription suffered little hindrance. Proportions of opium-based prescriptions dispensed by pharmacists declined slightly, but were increasing again by the 1870s .20 Direct over-the-counter sales to poorer customers were different only in that a pharmacist and not a general dealer was in charge, even though, as Dr Joyce's account of Rolvenden demonstrate (cited on p. 43), such consumers could suffer. Many of the features of the pre-1868 popular culture of opium remained undisturbed. Yet the long-term implications of the Act were significant. It established, at first albeit partially, that opium was a professional matter and that it must indeed be subject to some form of control. However laxly observed the regulations about the sale of opium were, however many exemptions proved acceptable in practice, a shift in attitude implicit in the public health/professional campaign had taken place and had received official legislative sanction.

References
2. For analyses of this process, see J. Bell and T. Redwood, Historical Sketch of the Progress of Pharmacy in Great Britain (London, Pharmaceutical Society, 1880), pp. 108-119, p. 208.


7. 31 and 32 Vict. ch. 121, 11868: An Act to Regulate the Sale of Poisons, and Alter and Amend the Pharmacy Act 1852.


16. The effects of the Act are discussed in further detail in V. Berridge and N. Rawson, op. cit.

17. Privy Council Office papers, P.C. 8,153, 1869, `Pharmacy Act 1868. Law Officer's opinion'.

18. `Sale of Poisons', Pharmaceutical journal, n.s. to (1868-9), pp. 500502. See also `The Privy Council and Pharmacy Act', Lancet, r (1869), p. 469, where the journal commented: `public safety will be better secured by a limited construction of the words "poison" and "preparations"'.


20. This conclusion is based on a survey of the prescription books already mentioned in Chapter 6.