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ARTICLE

The 'new era in medicine': John Ryle and the promotion of social medicine

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Abstract
John A. Ryle was Britain's first professor of Social Medicine. In the 1930s and 1940s, at the peak of his influence, he was a vigorous proponent of social medicine, then a relatively new, if contested, field. This article examines Ryle's views and activities under three broad headings: What was social medicine? What were Ryle's politics? Why prioritise medical education? We conclude with the apparent failure of the social medicine project, at least as envisioned by Ryle.

Keywords: John Ryle; social medicine; medical politics; medical education

Introduction

In 1947, John A. Ryle, Britain's first Professor of Social Medicine, addressed the New York Academy of Medicine, one of the prestigious lectures he delivered from the 1930s onward. Social medicine and social pathology, he claimed, should 'be considered respectively as the medicine and pathology of families, groups, societies or larger populations'. Just as human pathology was the 'related science of clinical medicine', social pathology could be 'viewed as the related science of social medicine'. If 'clinical medicine' was a 'comprehensive term', 'social medicine' was 'even more so'. It embraced all the activities of public health and 'the remedial and allied social services', and of the 'special disciplines' required to understand community sickness and health – for instance social surveys. All this presaged a 'new era in medicine'. Ryle's speech was noted in the medical press and more widely, for example in *The New York Times* and *The Times*.[1] Shortly afterward, George Rosen, medical historian, and prominent figure in American public health, analysed social medicine's history. Developments in Britain, led by Ryle and recently articulated in New York, were 'no doubt of great interest', holding 'considerable promise for the future'.[2] Superficially at least, then, Ryle was taken seriously by a leading exponent of social medicine. Nonetheless, as the above extracts indicate, Ryle's prose could be opaque, frequently indicating problems in conceptualising, defining, and describing an emerging discipline, and ambiguities around its future trajectory. Whatever his flaws, however, Ryle was, in his heyday, recognised as a major player in medical discourse.

This article examines Ryle's career as a socially committed medical practitioner seeking to spread his message as widely as possible; as engaged in contemporary politics, domestic and international; and as a vigorous proponent of the reform of medical education for the benefit not only of doctors, but of the whole population. It does so through previously under-utilised archival resources, and, especially,

[1]John A. Ryle, 'Social Pathology and the New Era in Medicine', *Bulletin of the New York Academy of Medicine* (June 1947), 312–29, 312–3; 'City Seen as Heart of Medical World', *The New York Times*, 7 March 1947, 19; 'Background of Health', *The Times*, 21 April 1947, 5.

[2]George Rosen, 'What is Social Medicine? A Genetic Analysis of the Concept', *Bulletin of the History of Medicine*, 21, 5 (1947), 674–733, 724.

published materials aimed at a range of audiences and, again, under-utilised in the existing historiography.[3] However, his strengths and impact notwithstanding, Ryle's version of social medicine proved problematic. His influence declined sharply after his death and the subsequent demise of the Oxford Institute he helped to found and which he led.

Ryle's career

Ryle trained at Guy's Hospital, London, before serving in the Royal Army Medical Corps during World War I.[4] Returning to Guy's in 1919, he acquired an impressive clinical reputation becoming, as Dorothy Porter puts it, by the early 1930s 'one of London's most eminent physicians'. His work was internationally recognised, and he was among those attending on the monarch.[5] In 1935, Ryle was appointed Regius Professor of Physic at the University of Cambridge, Britain's most prestigious clinical post. He told Edward Mellanby, Secretary to the Medical Research Council (MRC), that he was interested in moving to Cambridge 'for the sake of intellectual freedom' and the opportunity to apply certain ideas 'accumulated during 15 years of strenuous teaching and consultant work'. He was thus 'willing to give up a large and exacting practice and all its prospects'.[6] Correspondence ensued between Mellanby and H.R. Dean, Professor of Pathology and Master of Trinity College. In July 1935, Dean wrote that he and his colleagues were 'very much attracted by the idea of having Ryle here as Regius Professor'. He was known personally to some, and all knew his work. A few weeks later, Dean informed Mellanby that Ryle had visited Cambridge and seemed 'keen, clear headed and sincere'. The King's physician, Bertrand Dawson, had intervened on Ryle's behalf to ensure the availability of 'adequate facilities'. Dean had been 'overwhelmed by amazement' that Dawson 'should refuse or threaten to refuse his consent to an appointment' until assured that Cambridge was making 'proper provision for research'.[7]

But Cambridge was an unhappy experience, and World War II saw Ryle's return to Guy's, and an advisory role with the wartime Emergency Medical Service (EMS). In 1943, he resigned from Cambridge, subsequently taking up the Chair in Social Medicine at the University of Oxford and the leadership of the Institute for Social Medicine. All this was financially underwritten by the Nuffield Provincial Hospitals Trust, on whose Medical Advisory Committee Ryle had sat. Oxford University was supportive, its Registrar telling the Ministry of Health that Oxford was 'particularly fitted' for such developments, while its Regius Professor of Physic, Sir Farquhar Buzzard, promoted Ryle's appointment.[8] The newly founded Institute embraced both teaching and research. The distinguished statistician W.T. Russell, lately of the MRC, was among the staff and medical researcher May Mellanby told Ryle that 'I don't think anyone but you could have got him to leave his present job. You have won his heart absolutely'.[9] Along with Dean's observations and the support of leading physicians such as Dawson and Buzzard, a picture of an intellectually powerful, and charismatic, figure emerges.

[3]Ryle also produced more substantial works, notably *The Natural History of Disease* (Oxford: Oxford University Press, 1936), *Fears May Be Liars* (London: Allen and Unwin, 1941), and *Changing Disciplines* (London: Oxford University Press, 1948). However, the emphasis here is on interventions aimed at immediate impact.

[4]For a summary of Ryle's life, Dorothy Porter, 'Ryle, John Alfred', *Oxford Dictionary of National Biography* (Oxford: Oxford University Press/British Academy, 2004).

[5]Dorothy Porter, 'Changing Disciplines: John Ryle and the Making of Social Medicine in Britain in the 1940s', *History of Science*, 30, 2 (1992), 137–64, 141.

[6]Wellcome Library, Sir Edward Mellanby Papers (hereafter, Mellanby) PP/MEL/B.9, letter, 1 June 1935, Ryle to Edward Mellanby.

[7]Mellanby, PP/MEL/B.9, letters, 20 July and 9 August 1935, Dean to Mellanby.

[8]John Stewart, 'John Ryle, the Institute of Social Medicine and the Health of Oxford Students', *Family and Community History*, 7, 1 (2004), 59–71, 61–2 citing University Registrar; N.T.A. Oswald, 'A Social Health Service without Social Doctors', *Social History of Medicine*, 4, 2 (1991), 295–315.

[9]Mellanby, PP/MEL/F.44, letter, 24 July 1943, Lady (May) Mellanby to Ryle.

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At the time of his retirement, shortly before his death in 1950, *The Lancet* gave a positive spin on social medicine's upward path. Ryle's career reflected the last century's changes in medicine. Such was his success as a clinician and writer that 'many were surprised' when he left medicine's 'broad highway' to move to Cambridge. But those who knew him, aware of his 'growing preoccupation' with social problems and the need to reform medical education and practice, were less surprised. Wartime experience further 'deepened his interest in medicine as a community problem' and the Oxford Institute provided a 'congenial field for his talents', his time there being extremely productive. It became a 'centre of pilgrimage for students of social medicine', while Ryle travelled widely abroad to 'disseminate his ideas'. He would not be easily replaced but had left behind a 'strong team'.[10] Of a trip to India, Ryle told May Mellanby that it had been an 'amazing experience, but a very grim one', for example, because of the incidence of rickets.[11] Rickets was the sort of medical condition whose origins, often in poverty, social medicine sought to address.

In 1952, with the Institute's impending demise, *The Lancet* was more downbeat. As conceived by Ryle, it 'had not reached maturity when he died'. Many sharing his belief in its potential would be disappointed 'that it is now to be brought to an end – anyhow in its present form'. The article outlined some of the Institute's enquiries, and their findings were 'good evidence that the candle lighted … by Ryle had a penetrating beam'. It was thus to be hoped that 'the flame will not quite be extinguished'.[12] The same year, Iago Galdston, American social medicine proponent and sometime official of the New York Academy of Medicine, likewise assessed Ryle's legacy. Ryle was 'one of God's elect', and to have known him personally was 'to have had the privilege of an inspiring experience'. A modest man, Ryle was 'devoid of pretensions and unwilling, or incapable, to affirm with finality that which he knew or believed in only tentatively'. Galdston had visited Ryle and found him 'enthused in his discussions on social medicine and full of praise for his small band of associates at the Oxford Institute'. He had died too young, before his life and work 'had come to full fruition'.[13]

In both these pieces, there are further hints of social medicine's inherent problems. But what is important for immediate purposes is that Ryle, in the 1930s and 1940s, made an impact and was highly regarded by his peers. Examples of his status and interests can be found in his participation in the Committee for the Study of Social Medicine, set up in 1939. Interviewed in 2001, its Secretary, Philip D'Arcy Hart, explained that his committee, of around forty members, discussed the nature of social medicine, and how it might enable a more equal society. Participants also produced papers, including an enquiry into juvenile rheumatism, published in *The Lancet*. In addition to Ryle, its members included Jerry Morris and Richard Titmuss, joint authors of the juvenile rheumatism article and early proponents of social medicine.[14] A few years later, Ryle joined the Medical Planning Commission (MPC), set up by the British Medical Association (BMA) in 1941 to discuss post-war healthcare reform, serving on its General Practice Committee.[15] Charles Webster proposes that Ministry of Health officials paid close attention to the Commission, and to statements by leading members of the profession such as Buzzard and Ryle.[16] Meanwhile, a series of conferences on post-war reconstruction was organised by Nuffield College, Oxford. As Daniel Ritschel notes, attendees 'spanned nearly the entire range of wartime "progressive" opinion'.[17] Ryle chaired the 1944 meeting on health, which attracted around one hundred

[10]'Professor Ryle's Retirement', *The Lancet*, 21 January 1950, 126.

[11]Mellanby, PP/MEL/F.44, letter, 3 February 1945, Ryle to May Mellanby.

[12]'The End of an Institute', *The Lancet*, 15 November 1952, 976.

[13]Iago Galdston, review of Ryle's *Changing Disciplines*, *Journal of the History of Medicine and Allied Sciences*, 7, 3 (1952), 305–8;

[14]Geoff Watts, 'Why a 1940s medical committee should not be forgotten', *BMJ*, 18 August 2001, 360. On Titmuss, Morris, and social medicine, John Stewart, *Richard Titmuss: A Commitment to Welfare* (Bristol: Policy Press, 2020), ch. 9.

[15]British Medical Association Archives, BMA House, London, papers of the Medical Planning Commission (hereafter, MPC), Minutes of Commission, 7 May 1941, 5.

[16]Charles Webster, *The Health Services since the War: Volume 1 Problems of Health Care* (London: HMSO, 1988), 37.

[17]Daniel Ritschel, 'The Making of Consensus: The Nuffield College Conferences during the Second World War', *Twentieth Century British History*, 6, 3 (1995), 267–301, 273.

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participants, including both medical professionals and, for instance, local government representatives. Nonetheless, Ryle regretted that not more laypeople were present, indicative of his belief that healthcare was a society-wide concern.[18]

Ryle in context

Ryle's contribution to social medicine was widely recognised. Surveying the field internationally in the early 1950s, Belgian physician René Sand drew extensively on his activities, for example, through a careful account of the Oxford Institute's creation. For Sand, social medicine began when doctors moved beyond the 'Hippocratic condition' to record the patient's 'occupational, economic and domestic element'. It was thus 'a logical and necessary stage' in medical science's evolution. The latter had already borrowed from, for example, chemistry, so it was 'inevitable' that, to gain a fuller picture of its human subject, it would 'call on the social sciences and social service'. In employing 'collective methods', social medicine recognised the 'infinite variety of human personality', adapting its 'preventive or curative methods accordingly'.[19]

Around the same time, another survey was compiled by the English barrister, Samuel Leff, who too, was broadly sympathetic to social medicine and to Ryle. But Leff also highlighted their contexts, and their shortcomings. There was 'widespread frustration' with the recently created National Health Service (NHS), apparently focused on 'the curative services at the expense of the preventive health services'. All social medicine's proponents agreed that 'man must be treated as a whole', in both familial and social settings, while differing on 'the methods of introducing sociology into medicine'. Leff focused on the activities of Ryle and his Institute, what he called the 'Oxford' school and generally replicated in other British universities. Essentially, this involved Ryle's notion of 'the synthesis of the public health and personal health services'. The Institute had its achievements but remained open to criticism. It tended, for instance, to 'collect statistics merely to find correlations between factors, and consequently some of their studies become academic'. Its main weakness, however, was the 'arbitrary selection of the problems' it engaged with, these being 'unrelated directly to the practice of medicine and the life of the community'. Consequently, the Institute had failed to 'recruit or enlist the help of general practitioners or of the people themselves'. So, their analyses, although 'much broader than in the usual research in this field', had significant limitations.[20]

Ryle was not, however, operating in an intellectual vacuum. Richard Overy observes that the 'popularization of ideas about human biology and medicine' informed early twentieth-century British culture, partly because it allowed for broader social analysis.[21] Porter shows that Ryle paid close attention to those contemporaries who believed that science's social value was 'determined by its ethical basis', these including the crystallographer J.D. Bernal, and the biologists J.B.S Haldane, Julian Huxley, and Lancelot Hogben. She stresses too Ryle's holistic approach to health and medicine, especially his desire to 'reassert the "sick man", the 'whole-person', as the central object of the medical gaze', a position related to Bernal's suggestion that studying sickness should involve observing health.[22] And at the London School of Economics Hogben pursued the intellectual cross-fertilisation of biology and the social sciences.[23]

Stefan Collini likewise identifies Haldane, Hogben, and Bernal as scientists striving to bring scientific expertise to a wider public, so countering the narrowness of over-specialisation.[24] They were also central

[18]British Library of Political and Economic Science, Fabian Society Papers, G59/7, '14th Nuffield College Social Reconstruction Conference, March 25th–26th 1944, Reorganisation of the Health Services in Great Britain', opening remarks, 1.

[19]René Sand, *The Advance of Social Medicine* (London: Staples Press, 1952), 541ff, 563, 568–9.

[20]Samuel Leff, *Social Medicine* (London: Routledge and Kegan Paul, 1953), 7, 6, 9–13.

[21]Richard Overy, *The Morbid Age: Britain between the Wars* (London: Allen Lane, 2009), 366.

[22]Porter, *op. cit.* (note 5), 143. Bernal and Haldane were Cambridge colleagues of Ryle.

[23]Chris Renwick, 'Completing the Circle of the Social Sciences? William Beveridge and Social Biology at London School of Economics during the 1930s', *Philosophy of the Social Sciences*, 44, 4 (2014), 478–96.

[24]Stefan Collini, *Absent Minds: Intellectuals in Britain* (Oxford: Oxford University Press, 2006), 456–7.

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to Gary Werskey's 'Visible College' of left-wing scientists in the 1930s.[25] Huxley advocated 'scientific humanism' and, Chris Renwick comments, was 'a powerful synthetic thinker and communicator' committed to 'building dialogue between the disparate parts of biology and the world beyond natural science'.[26] In the post-war era, meanwhile, Titmuss and Michael Young, both close to the Labour Party, investigated enhancing hospital patients' experience, emotional and otherwise, in the new NHS.[27] As we shall see, Ryle shared these concerns, for example, in placing arguments before non-professional audiences, identifying with the political left, and pursuing scientific humanism.

Ryle's early career coincided with the onset, among advanced capitalist economies, of economic depression and political upheaval. Then came the most destructive war in history, followed by the Cold War. Social medicine responded to these challenges. So, for instance, in the 1930s, social investigations from 'the social medicine perspective' expanded, partly in response to the depression's 'public health effects'.[28] In Britain, this resulted in the 'substantial' growth of public health's sphere of influence, although Lewis makes the important qualification that this took place 'with little philosophical underpinning'.[29] Post-1945, the World Health Organisation (WHO), initially at least, owed much to a 'legacy' of social medicine, not least thanks to the contribution of Ryle's admirer, René Sand.[30]

Reflecting the decline of his vision of social medicine, commentary on Ryle languished after this death. Renewed interest came in the 1980s and 1990s, partly prompted by medicine's role in the 'surveillance society', and the ideas of Michel Foucault. In an influential work of 1983, medical sociologist David Armstrong highlighted the favourable historical conditions for social medicine's inter-war consolidation, how the Second World War opened the opportunity for 'an exhaustive surveillance machinery', and the centrality of surveys to the Oxford Institute's work.[31] But Ryle's most authoritative interpreter has been Porter. An early, co-authored, piece, raised a crucial issue, the apparent contradiction between the 'technocratic' version of social medicine, dependent upon 'scientifically-informed, technocratically determined actions by the state', and that involving 'theories of socialist medicine' wherein the state's role is political, not technical, seeking 'causes of health and sickness in the economic relations of production and the social relations of class'.[32] Porter did not, then, neglect Ryle's political ideas. However, one of her major preoccupations, with a discernible Foucauldian slant, was his philosophy of medical science.[33] Later studies have tended to focus on aspects of Ryle's career, or on the broader context in which he operated.[34]

[25]Gary Werskey, *The Visible College: A Collective Biography of British Scientists and Socialists of the 1930s* (London: Free Association Books, 1988).

[26]Chris Renwick, 'New Bottles for Old Wine: Julian Huxley, Biology and Sociology in Britain', *The Sociological Review Monographs*, 64, 1 (2016), 151–67, 154.

[27]Lise Butler, *Michael Young, Social Science and the British Left* (Oxford: Oxford University Press, 2020), 58–60.

[28]Marcos Cueto, Theodore M. Brown, and Elizabeth Fee, *The World Health Organisation: A History* (Cambridge: Cambridge University Press, 2019), 29–30.

[29]Jane Lewis, 'The Public's Health: Philosophy and Practice in Britain in the Twentieth Century', in Elizabeth Fee and Roy M. Acheson (eds), *A History of Education in Public Health* (Oxford, Oxford University Press, 1991, 195–229, 207.

[30]Randall M. Packard, *A History of Global Health: Interventions into the Lives of Other Peoples* (Baltimore: Johns Hopkins University Press, 2016), 99ff.

[31]David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge: Cambridge University Press, 1983), 40, 52.

[32]Dorothy Porter and Roy Porter, 'What Was Social Medicine? An Historiographical Essay', *Journal of Historical Sociology*, 1, 1 (1988), 90–106, 102.

[33]For example, Porter, *op. cit.* (note 5); *idem*, 'John Ryle: Doctor of Revolution?', in Dorothy Porter and Roy Porter (eds), *Doctors, Politics and Society: Historical Essays* (Amsterdam: Rodopi, 1993), 229-47; *idem*, 'Social Medicine and the New Society: Medicine and Scientific Humanism in mid-Twentieth Century Britain', *Journal of Historical Sociology*, 9, 2 (1996), 168–87.

[34]For example Oswald, *op. cit.* (note 8); *idem*, 'Training Doctors for the National Health Service: Social Medicine and Medical Education and the GMC, 1936–48', in Dorothy Porter (ed), *Social Medicine and Medical Sociology in the Twentieth Century* (Amsterdam: Rodopi, 1997), 59–80; Stewart, *op. cit.* (note 8); *idem*, '"Man against Disease"; The Medical Left and the Lessons of Science', in Don Leggett and Charlotte Sleigh (eds), *Scientific Governance in Britain, 1914–79* (Manchester, Manchester University Press, 2016), 199–216; Lewis, *op. cit.* (note 29) 207.

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All this is of considerable value. Nonetheless, there remains more to say. This article provides a more comprehensive account of Ryle and his activities by, first, fully engaging with his politics, and their undoubted contradictions and evasions. A key issue here is Ryle's equivocation about the relationship between social medicine and socialized medicine. Second, Ryle's medical science is duly acknowledged. But it is in his aspiration to convince audiences, professional and lay, of education's role in better equipping medical practitioners and in positively involving the general population in the pursuit of healthy communities. Ryle pursued a holistic approach to health and medicine, alongside a demand that patients be seen as fellow human beings and not just clinical cases. Social medicine, so realised, thus had the potential to transform medical science and practice, and society.

Social medicine

For Ryle, an important aspect of social medicine was reviving the doctor–patient relationship and rejecting over-specialisation and over-doctoring. While still an Assistant Physician at Guy's, he reported that the chief lesson of one of his cases was 'the inadvisability of operating and re-operating for abdominal pain in young women', not least because the patient had faked some symptoms.[35] Shortly afterward, he claimed it 'no exaggeration' that the profession was presently aware of 'disturbing and retrograde tendencies in modern medicine'. These included the neglect of 'the natural history of disease in man', hence the need for a reawakened interest in medical philosophy. Clinical science should be considered part of human biology, and so study 'man in disease'. This would embrace 'a study, at once broader and more intimate, of behaviour, personality, idiosyncrasy, vital reactions, and genetic factors' in patients. Certain fields of clinical research immediately lent themselves to such investigations, with positive outcomes including an end to 'fruitless surgical intervention'.[36]

In 1934, just before moving to Cambridge, Ryle addressed the Abernethian Society at St. Bartholomew's Hospital, London, on 'The Hippocratic Ideal'. Hippocrates had provided 'a foundation and an ideal' not subsequently bettered. It was, therefore, regrettable that medical education's 'practical demands', combined with continuous 'developments and discoveries' in 'clinical and ancillary sciences', had led to a neglect of 'early authority'. Doctors had become 'too knowledgeable and too specialised', so losing the ability to 'perceive and assess the components' constituting 'the intricate "whole" presented to us in the shape of a "disease" or a "sick man"'. Much 'unnecessary and unwise treatment' was avoidable if physicians and surgeons 'schooled themselves better' on 'the natural course and eventualities of disease' wherein sound prognosis and treatment depended. Such an approach acknowledged that although doctors could relieve suffering, they remained 'powerless in the strict sense to cure disease'. And if revising current ideas about the science and art of medicine must be the goal, this was more so regarding the 'ethical ideal'. Drawing on Hippocrates's 'wise humility' and 'strong exhortations to patient research and a love of both truth and man', old and new might ultimately be combined, so 'resolving present difficulties' and raising medicine's standards 'to a level at present beyond our vision'.[37]

In his Cambridge inaugural lecture, Ryle revisited medicine and medical professionals' shortcomings, especially 'The Defects of Specialism'. Specialism was certainly necessary for medical advance but could become excessive. The profession should recognise that, given the complex human problems medical practitioners confronted, specialisation could rarely 'give anything approaching the whole truth about a patient or his disease'. He had often encountered 'operations unnecessarily undertaken or advised, … treatments injudiciously selected, and forecasts unfairly given'. The problem was not medicine's 'inherent difficulties', but an insufficient appreciation of 'the nature and meaning of common

[35]John A. Ryle, 'Clinical Cases from Wards and Out-Patients', *Postgraduate Medical Journal*, 3, 30 (1928), 105–8, 107–8.

[36]'Discussion on Research in Clinical Medicine', *Proceedings of the Royal Society of Medicine*, 24, 2 (1930), 151–6, 151, 152, 153, 154.

[37]John A. Ryle, 'The Hippocratic Ideal', *The Lancet*, 8 December 1934, 1263–8, 1263, 1265–8.

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symptoms', the usurping of 'the function of eye, or ear, or hand, or native wit' by 'new machines and tests', and any previous misreading or neglect of the patient's psychology. In short, such patients had 'never been viewed as a "whole" man or woman, and the disease had never been studied as a "whole" disease'. Segregation and specialisation had advanced too quickly, and 'the task of integration' was now required. There was no cause to believe that laboratory medicine was any more 'scientific' than bedside medicine; hence, the need for better educational provision to train 'scientific physicians as well as medical scientists'.[38]

By 1939, Ryle had laid out ideas central to social medicine and was beginning to articulate what would now be designated the social determinants of health. Lewis cautions, however, that although there had undoubtedly been 'considerable discussion' of preventive medicine's meaning, the impetus for 'social medicine' came from 'academics in medical and social science'. Those directly involved in public health were 'at first puzzled' by the concept, before going on to reject it by the late 1940s.[39] This again suggests definitional issues, and who might practice social medicine. Nonetheless, from around 1941, Ryle stepped up propagandising through both lay and medical outlets.

In a letter to *The Times* that year, he noted a recent call for greater productivity in the engineering industries, including the use of 'every available man hour, both managerial and operative'. But the 'human machine, however willing', when asked to 'contribute "every available man hour"', was inevitably less productive than when dealt with by rules, resulting from careful study, laid down by doctors, psychologists, and physiologists. Environmental and psychological factors contributed to 'industrial fatigue'. Its symptoms were unquantifiable but its consequence, 'falling output', was. Greater understanding was therefore needed of 'this very vital aspect of the production problem'.[40] Ryle was clearly aware of both the wartime economy's demands and contemporary developments in industrial psychology.[41]

In early 1943, Ryle told George Scott Williamson of the pioneering Peckham Health Centre that he had long tried to 'think of medicine as "the biology of Man in health and disease"', while urging that research embrace 'a broader, but also closer, study of man in his relation to his environment'.[42] Shortly afterward, he told readers of *The Times* that medical students currently learned 'little of the foundations, meaning, or measurement of health', rarely seeing a 'healthy subject'. For most, 'the glamour of medicine' lay in clinical intervention, but 'the totality of lives and limbs saved by this means, great though it be, is infinitesimal in comparison by that saved by preventive methods'.[43]

Ryle's Oxford appointment produced a major programmatic statement that, indicative of contemporary interest, occupied the first four pages of *The BMJ*. Social medicine, Ryle began, had recently been widely discussed in both medical and lay circles, although the term was not always fully understood. It was professionally acknowledged that, over the last quarter-century, medicine had become more technical and more specialised. Consequently, doctors gained a 'less and less intimate understanding of the patient as a whole man or woman with a home and anxieties and economic problems and a past and a future and job to be held or lost'. Technique and science now dominated at the expense of 'the most important science of all – the science of man – and the most important technique of all – the technique of understanding'. Science without 'humanism may work with atoms', but not human beings. However, the 'third epoch of preventive medicine' was imminent. The first had been that of sanitary reform, the second

[38]John A. Ryle, *The Aims and Methods of Medical Science: An Inaugural Lecture* (Cambridge: Cambridge University Press, 1935), 11–14, 38–44.

[39]Lewis, *op. cit.* (note 29), 204.

[40]John A. Ryle, letter, 'War Production', *The Times*, 2 October 1941, 5.

[41]John Stewart, 'Psychology in Context: From the First World War to the National Health Service', in John Hall, David Pilgrim, and Graham Turpin (eds), *Clinical Psychology in Britain: Historical Perspectives* (Leicester: British Psychological Society, 2015), 39–51, especially on C.S. Myers.

[42]Letter, 13 January 1943, Ryle to Williamson, cited in Jane Lewis and Barbara Brookes, 'A Reassessment of the Work of the Peckham Health Centre, 1926–1951', *The Milbank Memorial Fund Quarterly*, 61, 2 (1983), 307–50, 339–40.

[43]John A. Ryle, letter, 'Health Policy: Claims of Social Medicine', *The Times*, 24 July 1943, 5.

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'the attack on the chronic infective diseases' such as tuberculosis and rheumatic heart disease, and here Titmuss's and Morris's work was cited.

Addressing issues such as housing, and recognising that many diseases were preventable, marked the third epoch's arrival. Improvements in diet, housing, recreational and cultural opportunities, employment conditions, and social services would produce human and economic benefits 'to the individual and to the State' compared to which the last century's 'remarkable advances in remedial medicine and surgery', valuable as they were, 'would make but a poor showing' – the point recently made in *The Times*. Apart from a relatively small 'social problem' group, there was 'no good evidence of genetic inferiority among the poorer classes', so opportunities were now available for the 'ultimate amendment by economic and environmental changes'. As someone whose 'training and teaching for more than 25 years' had been essentially clinical, he had come to believe that social medicine, its necessary association with 'public hygiene' notwithstanding, was a 'logical development from and a direct expansion of clinical medicine'. Its 'ideas and tasks' might justifiably be seen as the most essential contribution 'to the developing philosophy of scientific humanism'. This piece was reproduced shortly afterward in America, further indicating its perceived significance.[44] May Mellanby complimented Ryle on producing 'just the type of article needed to emphasise the importance of the subject'. Acknowledging problems in communicating the message, however, she added that 'so few people, medical or lay', fully appreciated its implications.[45]

Ryle sought to spell these out. In 1943, he wrote in *The Manchester Guardian* that the 'health and welfare of the expectant mother, the mother, the infant, the child, and the adolescent' had more than ever become 'an essential concern of the modern community and its social services', a concern dictated not just by humane considerations but also by 'urgent national and political necessity'. Ryle drew on Titmuss's recently published *Birth, Poverty and Wealth*, a copy of which Titmuss had sent him and showed the 'very unequal chances of survival among the newly born at the two extremes of the social scale'. If mothers and children had 'such high racial value', they should be 'the first charge on the nation's exchequer'. Among Ryle's proposals for attacking excessive infant and maternal mortality was the 'organisation of a national medical and health service', with expanding powers for social and preventive medicine, with all medical training directed toward 'a wider understanding of the beginnings of life and the betterment of maternal and child health'.[46]

Ryle also addressed mental health against a background, stemming from the inter-war era, of fears about the spread of 'neurosis'.[47] His 1947 Maudsley Lecture on nosophobia (fear of illness) drew on numerous case studies, including that of his colleague, R.W. Parnell, into the health of Oxford students. For too long, clinicians had 'separated psyche and soma, past and present, organism and environment, individual and society, in our attempts to fathom Man'. So might not an 'interest in a primitive emotion such as fear, in which the interdependence of all of these is manifest, have value?'. Ryle traced the history of responses to illness, concluding that modern individuals, although 'more sophisticated' than their forebears, suffered from 'the abundance of half-knowledge' that had replaced ignorance, and from 'enslavement'. Addressing their fears would contribute 'to curative and preventive medicine and to individual and communal health'. Ryle then outlined nosophobia's types and causes, how it could affect anyone, whatever their level of mental and emotional stability, and current professional failings in diagnosis and treatment. Nosophobia was widespread, a social as well as an individual problem, and contributed strongly to much 'present-day neurosis', notwithstanding that 'we command more instruments for the protection of life and relief of sickness than in any previous age'. Dealing with the condition was not, unlike some other studies in the natural history of disease, readily amenable to 'objective and

[44]John A. Ryle, 'Social Medicine: Its Meaning and Its Scope', *BMJ*, 20 November 1943, 633–6; and *idem*, *Milbank Memorial Fund Quarterly*, 22, 1 (1944), 58–71.

[45]Mellanby, PP/MEL/F.44, letter, 18 December 1943, May Mellanby to Ryle.

[46]John A. Ryle, 'The Nation and the Newly Born', *The Manchester Guardian*, 13 November 1943, 4, 6; Ann Oakley, *Man and Wife: Richard and Kay Titmuss: My Parents' Early Years* (London: Flamingo, 1997), 192.

[47]Overy, *op. cit.* (note 21) ch 4.

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numerical methods of enquiry'. But he had frequently seen 'the fears of the sick and injured, in peace and war, go sadly under-estimated'. It was thus more necessary than ever 'to strike a just balance' between materialist and humanist science.[48]

Around the same time, Ryle addressed a central premise of social medicine, that health and disease 'know no sharp boundary', for this could exist only if biology could 'adopt the dictionary definition of normality'. Variability, however, was one of life's 'most distinctive and necessary attributes', for the species and over time, thus allowing for 'no constant and no norm'. Although the word 'normal' was frequently employed in medicine, usually as a synonym for 'healthy', neither could be satisfactorily defined. Not studying those deemed healthy, and 'normal variability', resulted in certain conditions being designated 'abnormal', and hence to '(i)naccurate diagnoses, faulty treatments, and unnecessary invalidism'. Structurally and functionally 'every organ and tissue' displayed 'a natural range of variability in any population studied and in the species as a whole'. Medically and biologically, then, the 'normal' was better understood in terms of this variability than by 'a hypothetical mean or standard'. Physicians had been diverted by a '(p)reoccupation with sick persons' at the expense of studying 'ostensibly healthy populations', a better way to understanding 'normal variability'. Variations arose for many reasons but should always 'be considered in relation to environment' which had been shown to impact strongly on 'physical, mental, and emotional equipment' and their predispositions to health and disease. The 'normal' and the 'healthy' were not, therefore, static phenomena. Individuals and populations could be placed on a spectrum rather than at fixed points – hence the lack of the 'sharp boundary' between health and disease.[49] This issue had concerned Ryle for some time, and as a problem not just for doctors. In 1943, he thanked May Mellanby for sending him articles on dental health, one of her principal research concerns. He had noted their 'neglect of knowledge of the normal and its variations', evidently as prevalent in dentistry as in medicine. It was 'strange' that the healthy organism had never been 'systematically studied and that students and doctors learn their "standards" from sick people'.[50]

These observations also related to the Institute's survey of child health. In 1942, Ryle suggested that 'field surveys' should take future social medicine students 'from the hospital to the homes of the people', and to workplaces such as factories and mines, 'at times to live and work in them'.[51] Two years later he told Industrial Medical Officers that, like social medicine, industrial medicine, embraced 'the study and the service of community health and sickness', with each likely to 'employ common methods of socio-medical enquiry'. There was no satisfactory definition of social medicine, partly because the 'subject is too large' (a revealing confession). It was, nonetheless, concerned with 'the man–environment relationship', material and personal. Social medicine could be legitimately described as a discipline, 'for, like clinical medicine, it is not a science nor yet, on the other hand, to be considered merely as an art or mode of practice'. Ryle then gave an historical account of 'the three distinct, if overlapping, disciplinary periods', namely the pathological, the experimental or laboratory, and the technological. Each had contributed significantly to medicine, while tending to 'distract attention from the patient as a person' and as a member of a family and of the wider society and, thereby, from 'those domestic, occupational, economic and other stresses' often the background to disease and disability. Giving an example of the Institute's work, Ryle cited its first 'field-survey', a study of the 'health, growth and development and infection-experience' of Oxford's pre-school children. A large sample, covering all social classes, was employed. The survey was in welfare centres, involved 'correlated clinical, anthropometric and social studies and a three-monthly follow-up', and was to be carried out by a team comprising a paediatric research assistant and a social worker, under Ryle's supervision, and W.T. Russell.[52]

[48]John A. Ryle, 'The Twenty-First Maudsley Lecture: Nosophobia', *The Journal of Mental Science*, XCIV, 394 (1948), 1–17, 1, 2, 5–6, 16. On Parnell's survey, Stewart, *op. cit.* (note 8).

[49]John A. Ryle, 'The Meaning of Normal', *The Lancet*, 4 January 1947, 1–5, 5, 1, 4, 5.

[50]Mellanby, PP/MEL/F.44, letter, 31 July 1943, Ryle to Lady Mellanby.

[51]John A. Ryle, letter, 'Social Medicine', *BMJ*, 27 June 1942, 801.

[52]John A. Ryle, 'Social Medicine as a Discipline', *British Journal of Industrial Medicine*, 2, 2 (1945), 108–10.

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The 'socio-medical enquiry' was a key social medicine tool and could take three forms – the collation of existing statistical material, the 'social experiment', and, as with Oxford's child health, 'the planned survey embracing both clinical and relevant social and environmental studies'. This 'socio-medical survey' involved 'the ordered observation of sickness and health in human groups' and 'their relationships with the conditions to which these groups and their several fractions are subjected'. Accuracy in observation and recording were important, but not the whole picture. Surveyors should have a sympathetic approach and be sensitive to the interviewees' particularities. Whenever possible, surveyors and their subjects 'should be encouraged to regard themselves as essential partners in the inquiry', and the results widely broadcast.[53] So, for instance, the Institute's study of Oxford student health generated a conference in 1947, leading to the Oxford-led coordination of university student health services 'to achieve comparable records and statistics'.[54]

Ryle's domestic politics

In the 1944 article outlining his vision for social medicine, Ryle addressed the current confusion 'between social medicine and socialized or State medicine'. The former had 'no immediate concern with medical or other politics'. Some believed that 'social and individual medicine' would be improved under a 'reorganized, co-operative and comprehensive medical and health service'. But such propositions were 'no more a function of social medicine than … the nationalization of the chemical industries is a function of the chemical sciences'.[55] Superficially, this seems plausible. It was, however, articulated during widespread debates over post-war social reconstruction, and disingenuous. The 'chemical' analogy does not work, not least since Ryle's pursuit of 'scientific humanism' involved close collaboration between biological and social sciences. So, if much ill health resulted from adverse social conditions, then logically such conditions should, in the pursuit of improved individual and social health, be ameliorated.

Ryle was on the political left, although careful to deny any specific affiliation, possibly on the advice of his wife, Miriam.[56] In 1940, he contested, unsuccessfully, a parliamentary by-election for a Cambridge University seat as an Independent. His sympathies, he claimed, were 'always with the Opposition', suggesting hostility to the National (Conservative) government without committing to any other party. He stood as 'an academic representative of medicine' while being 'keenly interested in matters of health and social problems and education'.[57] A few months later, at the height of the Blitz, he urged Cambridge medical students to play their part in building 'the new Jerusalem in England's green and pleasant land'.[58] The last phrase was soon to be associated with Labour's post-war aspirations, but used rather coyly here while avoiding any specific allegiances.

This political coyness was manifested in Ryle's relationship with the Socialist Medical Association (SMA). Founded in 1930, and affiliated to the Labour Party, the Association organised left-wing medical professionals.[59] On Ryle's death, a proposed memorial meeting was rejected as he was not an SMA member.[60] But Ryle and the Association were in close contact, each influencing the other's approach. David Stark Murray, founding SMA member, later recalled Ryle's talk to the Association on the need for improved social services and more 'social teaching' in medical education. Consequently, a series of

[53]John A. Ryle, 'Socio-Medical Surveys', *The Lancet*, 12 January 1946, 64–6, 64, 65, 66. For an example of the collation of existing material, John A. Ryle and W.T. Russell, 'Social and Occupational Factors in the Aetiology of Skin Cancer', *BMJ*, 21 June 1947, 873–77.

[54]'The Nuffield Foundation', *Nature*, 163 (1949), 224–25.

[55]Ryle, *op. cit.* (note 44), 635.

[56]Porter, *op. cit.* (note 5), 151.

[57]'Cambridge Seat. Two Independent Candidates?', *The Manchester Guardian*, 20 January 1940, 9.

[58]John A. Ryle, 'Today and Tomorrow', *BMJ*, 16 November 1940, 657–9, 659.

[59]John Stewart, *'The Battle for Health': A Political History of the Socialist Medical Association, 1930–51* (Aldershot: Ashgate, 1999).

[60]Brynmor Jones Library, University of Hull (hereafter, Brynmor Jones), Papers of the Socialist Medical Association, DSM 1/3, Minutes of the Executive Committee, 15 March 1950, 3.

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meetings was arranged on 'aspects of public health which appeared to be largely omitted from the teaching of medical students'.[61] This was further prompted by the Association's student committee receiving 'many complaints regarding the inadequate way in which Public Health is taught in the London medical schools'.[62] It was subsequently recorded that these meetings had been 'much appreciated', with all 130 seats sold before the first event.[63]

At the 1942 meeting, which initiated these events, Ryle argued that, currently, medicine studied 'disease in the patient detached from his environment', preventive medicine 'disease in the environment detached from the patient', and pathology 'disease in the laboratory detached from the patient and the environment'. In future, these three should collaborate more closely, and all 'must have an interest in the patient in relation to his environment'.[64] Ryle then moved on to social medicine, citing a recent article by Titmuss and Morris as exemplifying how appropriate research could be carried out. Titmuss was present, subsequently writing to Morris: 'Magnificent meeting – crowds standing. Ryle: sane, logical, quietly humorous, states the case (and states it well) for State Salaried Service'.[65] Further illustrating their dynamic intellectual relationship the SMA, too, agitated for a 'third way' in public health.[66]

Following the 1945 general election, Evan Durbin, Labour MP and economist, organised a conference on 'the psychological and sociological problems of modern socialism'. Ryle was among those invited along with, inter alia, the author of Labour's 1945 manifesto, Michael Young.[67] Another analysis of this event, although not specifically mentioning Ryle, likewise emphasises its socialist credentials, and Durbin's rejection of over-specialisation in the social sciences – a notable parallel with Ryle's ambitions for medicine.[68] Ryle's invitation illustrates his standing on the left, and as a prominent medical professional. Unsurprisingly, he advanced a radical position on post-war healthcare reconstruction. His 1942 MPC memorandum, 'A Whole-Time State Medical Service', noted that his General Practice Committee was moving toward a compromise between a state medical service and the 'existing order'. But it would be more efficient for the nation, and for doctors 'a happier service in the long run', were compromise rejected and the 'whole-time principle' accepted. For the medical profession, directly employed by the state in the interests of the whole community, the underlying rationale would be 'one of personal service'. There should be a unified, state-directed, hospital service under municipal or regional control, with teaching hospitals supervised by universities. Were all this realised, Britain's medical profession would change from being 'one of the most conservative bodies in the world, combining altruism and self-interest to a remarkable degree', to 'pioneers of the new order', so fulfilling 'the Hippocratic ideal more effectively than at any time in our history'.[69]

A few months later, addressing Medical Officers of Health (MOsH), Ryle reflected on his experience on various enquiries, including the MPC and as a 'Consultant Adviser' to the EMS. Any attempt to accommodate the voluntary sector, or coordinate it with public hospitals, would 'involve loss of efficiency and a perpetuation of much that is patently unsatisfactory'. A unified hospital system was required, working 'as an integral part of a full national medical and health service', a service 're-constituted and recruited on a whole-time salaried basis'. It should also include the 'general practitioner, consultant and specialist services' and everything embraced by public health, and social and industrial

[61]D. Stark Murray, *Why a National Health Service?* (London: Pemberton Books, 1971), 58.

[62]*SMA Bulletin 51*, January 1943, 2.

[63]*SMA Bulletin 52*, February 1943, 1.

[64]Brynmor Jones, Unclassified Somerville Hastings Papers, File 8, Social Medicine, clipping from *The Medical Press and Circular*, 11 November 1942, extract from address given by Professor John Ryle to SMA meeting, October 1942, on 'Social Medicine', 323–4, 324.

[65]Cited in Oakley, *op. cit.* (note 46), 196.

[66]Stewart, *op. cit.* (note 59), 143–4.

[67]Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth Century Britain* (Oxford: Oxford University Press, 2006), 231–2.

[68]Butler, *op. cit.* (note 27), ch1.

[69]MPC, General Practice Committee, Minutes, 14 January 1942, memorandum by Ryle, 'A Whole-Time State Medical Service', 1, 2, 8–9, 10.

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medicine. For the first time in its history British society was 'seriously contemplating a planned society'. Medicine must participate 'and could lead the way in planning'. Indeed, so important were 'its potentialities and its objectives' they might become 'the spear-head of the advance towards our new order'.[70]

Responding to the wartime government's White Paper on healthcare, Ryle wrote to *The Times* that, notwithstanding many defects, it constituted the greatest attempt by any British government 'to secure for all classes equality of opportunity' in medical and health services. Social justice in healthcare did not currently exist, nor could it 'be ensured by the old systems'. These had had their opportunity and been found wanting. Unequal access was largely due to 'environmental and social factors over which the doctors have no immediate control' but should, nonetheless, be a major professional concern. However, Ryle rejected any extension of professional powers in the short term as many doctors' views were 'patently sectional', lacking 'social understanding or democratic feeling'.[71] This was an argument widespread on the medical left, that doctors had a 'vested interest' in ill health, and were inherently reactionary. Such a view was reinforced by the BMA's at best equivocal stance on medical reconstruction.[72]

Nonetheless, Ryle generally adopted a positive approach. In spring 1945, he took on pillar of the medical establishment, Lord Horder. Paraphrasing one of Horder's recent speeches, Ryle argued that suggesting doctors not be 'political' implied that practitioners could not be 'both a good doctor and a good citizen'. But no individual could fully develop their functions in either capacity 'without being interested in policies affecting the welfare of the community'. Although politics should be kept out of medical practice, it was surely 'wholly proper' that doctors, where capable, 'play a part in local government'. They should likewise support parties pursuing the national interest, and 'sometimes occupy seats in the House of Commons – or even in the House of Lords!'. His support for 'a full national medical service' derived from his sincere belief that this was 'ultimately in the best interests of both the people and the profession of medicine'.[73]

Ryle's international politics

A-E. Birn and Theodore Brown argue that, in the 1930s, potential arose for a militant 'health internationalism', fusing social medicine and left-wing politics. This was problematic because of, for example, competition from bodies such as the American philanthropic body the Rockefeller Foundation and the League of Nations Health Organisation, inclined to social medicine but not to socialism. Disagreements notwithstanding, social medicine continued to develop with Ryle, Titmuss, and Morris its leading British proponents.[74] Ryle was thus part of an inter-war international movement, albeit one with ill-defined and contested boundaries. This contextualises his concerns over international affairs. F.A.E. Crew, Professor of Social Medicine at the University of Edinburgh, noted that following his Cambridge appointment 'Ryle the rationalist was turning more and more to the left politically', as witnessed by his commitment to the Anglo-Soviet Medical Committee, and becoming 'pacifist in outlook'.[75] The latter saw Ryle taking on the Presidency of the Medical Peace Campaign, telling the medical press that a 'calm scientific approach' was needed, with the profession encouraged to debate war

[70]John A. Ryle, 'The Future of the Hospital Services', *Public Health* (October 1942), 5–6.
[71]John A. Ryle, letter, 'National Health Service', *The Times*, 16 June 1944, 5.
[72]Stewart, *op. cit.* (note 59), passim.
[73]John A. Ryle, letter, 'Should We Nationalize Medicine?', *BMJ*, 31 March 1945, 456.
[74]A-E. Birn and Theodore M. Brown, 'The Making of Health Internationalism', in A-E. Birn and Theodore M. Brown (eds), *Comrades in Health: U.S. Health Internationalists, Abroad and at Home* (New Brunswick: Rutgers University Press, 2013), 15–42, 27–8.
[75]F.A.E. Crew, 'Obituary: John Alfred Ryle', *British Journal of Social Medicine*, 4, 3 (1950), 172–3, 172.

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and its causes 'much as it debates the aetiology and prevention of disease'.[76] Overy remarks that nothing 'provoked greater anxiety' in inter-war Britain 'than fear of war', and Ryle's interventions, and pathologizing of conflict, should be seen in this light.[77]

Pacifist inclinations notwithstanding, Ryle understood the need for war preparations as the 1930s ended. In 1937, he urged more comprehensive planning for casualty evacuation in the event of aerial attack, with the contemporary Spanish conflict demonstrating what might be expected. One solution might be the formation, with bodies such as the Quakers and the Red Cross, of a civilian ambulance service staffed by the many doctors 'unwilling, for conscientious reasons, to serve with the armed forces in any future war'. This would serve the national interest while helping 'to disarm bitterness and avert a vast amount of unhappiness in connexion with conscientious refusal to give military service'.[78] Another letter the following year, in *The Times*, captures Ryle's pragmatism alongside his loathing of conflict. War preparations, including evacuation from urban areas (something being urgently considered at the time), should embrace as a 'foremost concern and sacred trust' children's care and protection. Children were conflicts' innocent victims and 'builders of the future'. Alongside shielding from 'physical violence' they should be enabled to 'breathe an atmosphere of humanity and love', preferably far from 'spectacles of inhumanity and hate and death'.[79] Ryle also railed against the inadequacy of government plans for air raid precautions; urged that Austrian medical students under threat in their own country be accommodated by British medical schools; and was co-signatory to a letter following the Austrian Anschluss noting that 'many revered physicians and surgeons' were likely to be viewed unfavourably by the Nazi regime because of their 'medical or social views', or through being Jewish. Doctors of all nationalities should be vigilant, and 'stand by any members of our profession who may suffer hardship under the new *regime*'.[80]

The war's end transformed the international context, including its medical and healthcare dimensions. For example, Andrew Seaton shows how the Rockefeller Foundation saw, in Britain's NHS, the possibility of implanting its interest in social medicine.[81] Late 1945 found Ryle pondering the development of atomic energy and nuclear weaponry. These demonstrated science's 'immense and ever-expanding potentialities' and 'the immediate power' held by scientists. The latter's role had previously involved a 'certain detachment from human affairs'. But, in these new circumstances, they should accept their functions 'as leaders in world citizenship' and so must continually define 'their particular duties and their rights'. Although they had always worked according to 'certain ethical ideals', scientists had yet to delineate 'a clear or comparable ethical code' on the relationship between scientific discoveries and human society. A 'provisional charter of rights and duties', formulated by professional bodies worldwide and endorsed by the general population, would be a uniquely important historical intervention while helping reverse 'a declining faith in the intelligence and prospects of man'. Underpinning any new approach 'an alliance of science and humanism' in school and university education was ever more necessary. Moral issues were 'not a prerogative of the philosopher and the theologian', nor could they 'thrive in dissociation from other specific intellectual activities'.[82]

The context here was not only the advent of atomic weapons and the Cold War. Ryle's article was published shortly after the beginning of the Nuremburg Trials, where Nazism's full horrors, including its immoral and unethical use of medical science, emerged. It is revealing, too, that Ryle agreed with Huxley that 'history had hitherto been dominated by the physical sciences which had built the technologies of

[76]John A. Ryle, letters, 'Medical Peace Campaign', *The Lancet*, 22 May 1937, 1250–1, 1250, and *BMJ*, 22 May 1937, 1092. For a further example, *idem*, 'Foreword' in Horace Joules (ed), *The Doctor's View of War* (London: George Allen and Unwin, 1938).

[77]Overy, *op. cit.* (note 21), 175 and chs 5 and 6.

[78]John A. Ryle, letter, 'A Civilian Ambulance Service', *BMJ*, 20 March 1937, 635–6.

[79]John A. Ryle, letter, 'A.R.P. Plans – The Evacuation of Children – A Weapon Against Panic', *The Times*, 9 May 1938, 15.

[80]John A. Ryle, letters, 'Air Raid Precautions', *BMJ*, 12 June 1937, 1230, and 'Assistance to Medical Students from Austria', *BMJ*. 11 June 1938, 1286; and W. Russell Brain *et al*, letter, *The Spectator*, 25 March 1938, 520.

[81]Andrew Seaton, 'The Gospel of Wealth and the National Health: The Rockefeller Foundation and Social Medicine in Britain's NHS, 1945–60', *Bulletin of the History of Medicine*, 94, 1 (2020), 91–124.

[82]John A. Ryle, 'Science and Ethics', *Nature*, 156, 3969 (24 November 1945), 619–21.

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mass warfare'. It was, then, the joint mission of biological and social science to 'build the technologies for peace and social harmony'.[83] Others articulated these concerns. Henry Sigerist, leading American advocate of social, and socialised, medicine spoke on 'Nationalism and Internationalism in Medicine' around the time of Ryle's paper. He reasserted medicine's, and especially public health's, international nature, notwithstanding the recent 'orgy of nationalism' which had almost destroyed the world. The creation of the WHO, whose constitution reflected 'a very broad attitude toward the problems of health and disease', was a positive development. But although science and technology had greatly advanced, 'civilization' had not kept pace. Physicists and chemists were permanently afraid 'that their discoveries will be used for the destruction of mankind'. However even in modern 'barbaric wars' medical personnel treated 'friend and foe without discrimination. Physicians should, therefore, be ambassadors of good will', helping promote 'understanding between nations' and so combatting 'nationalistic prejudices'.[84] Ryle and Sigerist, leading advocates of social medicine, thus held closely aligned views on the ongoing necessity of medical internationalism.

Education for health

Reforming medical education was fundamental to Ryle's vision, another area where Sand drew on his arguments.[85] Lewis proposes that social medicine was primarily an attempt by its academic teachers 'to rethink the philosophy of public health, emphasizing the "social relations of health"', and, consequently, change medical education's orientation 'towards the public health point of view by placing "medicine in the matrix of society"'.[86] In his 1938 Galton Lecture, Ryle agreed that doctors should retain their 'privileged position as comforter and healer and in many emergencies as a saver of life and limb'. But they must embrace, too, instructing 'individuals, municipalities and governments that many forms of chronic disease, disability and mental and physical ill-health' were preventable.[87] Medical education, then, involved the wider population as well as the medical profession. Even war provided opportunities. In late 1939, Ryle urged the formation of medical societies for those on active service. Many doctors, himself included, recalled the 'medical and surgical experience of the last war as one of the most vivid and instructive experiences of a lifetime'.[88]

Ryle's 1940 address to Cambridge medical students recognised the 'privileges' his audience enjoyed, including medicine as almost the 'only scientific career remaining' not in some way concerned with the destruction of life. Medical education should embrace, though, more than study. Students must develop themselves as citizens, for the doctor 'who is not a good citizen is not a complete doctor'. By whatever means, they should enlarge their social conscience something which, 'in the view of many of us', had been 'too little evident in the years preceding the war'. Doctors tended to hold themselves 'too much aloof from the larger social problems'. But social 'selfishness and abuse of privilege are diseases as troublesome' as any described in medical textbooks. The present student cohort had to 'teach the people, both those who suffer and those who pay too little heed to suffering', how to rebuild society. Cambridge's medical school was among 'the best and most famous in the world', but the institution and its curriculum could undoubtedly 'be much better'.[89]

The following year, amid widespread discussion of post-war reconstruction, saw another long *BMJ* piece. Ryle's starting point was the much-needed reform of medical education, not least because the

[83]Porter, 'Social Medicine and the New Society' *op. cit.* (note 33), 178.

[84]Henry E. Sigerist, 'Nationalism and Internationalism in Medicine', *Bulletin of the History of Medicine*, 21, 1 (1947), 5–16, 6, 13, 14–16.

[85]Patrick Zylberman, 'Fewer Parallels than Antitheses: René Sand and Andrija Stampar on Social Medicine, 1919-1955', *Social History of Medicine*, 17, 1 (2004), 77–92, 78, 85.

[86]Lewis, *op. cit.* (note 29), 197.

[87]John A. Ryle, 'Medicine and Eugenics', *The Eugenics Review*, 30, 1 (1938), 9–19, 11.

[88]John A. Ryle, letter, 'Active Service Medical Societies', *BMJ*, 16 December 1939, 1202.

[89]Ryle, *op. cit.* (note 58), 657, 658, 659.

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profession's 'philosophy has not kept pace with technical achievement'. Among his proposals was that psychological medicine 'inspire the daily teaching of medical and surgical wards' rather than being 'wholly concentrated in a department'. The need for a more broadly based course in social medicine was becoming more widely accepted and would encompass the 'origins of ill-health and the social responsibilities of the doctor', so replacing 'the present dull teaching on "public health"'. Overall, should the best be extracted from 'old experience and new experiment', then 'the proper place and proportion from each science and service in the complex structure' of medical education and medical science would be realised.[90]

Ryle's concerns were widely shared. In 1943, an official enquiry, The Interdepartmental Committee on Medical Schools (the Goodenough Committee), was formed. William Goodenough was financial advisor to Lord Nuffield, and chair of the Nuffield Trustees. As Oswald suggests, his committee 'was intended to propose radical changes in medical education for a future health service'.[91] The BMA was among its witnesses, proposing that medical students receive 'practical instruction in the recognition of the normal' in children and adults and of 'the early manifestations of disease', and in the 'social circumstances underlying disease'.[92] The *BMJ* noted that the Committee's 1944 report advanced 'radical changes', given that the attention currently paid to social medicine, health promotion, and disease prevention in most medical schools was 'often perfunctory and largely divorced from the rest of the student's training'.[93] Richard Boulton argues that Goodenough effectively recognised that 'there are social determinants to illness and medicine' (although he notes too that a clear sense of what constituted the 'social' was absent).[94] Nonetheless, Oswald conclusively shows that, post-war, General Medical Council and teaching hospital resistance meant that the Report's radicalism, including any reorientation toward social medicine, was squashed.[95]

Before this became apparent, Ryle continued to argue for reform. He told the Cardiff Medical Society in spring 1944 that of the 'effective instruments of social and individual medicine, or social and individual hygiene – for these are scarcely separable – by no means the least is health education'. Medical education and practice had, historically, emphasised sickness, resulting in 'a curious neglect of those more balanced processes of body and mind from which all sickness is a departure'. Ryle reminded his audience that the word 'doctor means a teacher, and that the function of teaching, as distinct from therapeutics, has been too long and largely in abeyance'. Future national fitness required a 'fruitful marriage of our health and educational services'. Everyone should be educated in health, with groups meriting particular attention, for example, infants, children, and adolescents. These were 'not only in a pliable phase of life' but also 'unembarrassed by prejudice or the pressure or conflict of affairs'. Health as 'a duty, and not only a right of citizenship' could be 'a suitable and arresting subject for lectures and discussion groups', especially for adolescents and young adults.[96]

In his 1944 talk to Industrial Medical Officers, Ryle claimed it 'surely significant' that the Goodenough Committee and a recent Royal College of Physicians memorandum stressed 'the urgent need' for improved undergraduate instruction in social and psychological medicine. The Oxford Institute's philosophy was that social medicine was not 'another special study' and must be taught alongside clinical medicine. In the Institute's first year, he had lectured on its 'broader scope and aspects', including studies of diseases such as rheumatic fever and peptic ulcer (both investigated by Titmuss and Morris), each being discussed as social, rather than clinical, problems. Further talks were given by public health doctors and on the medical social worker's 'province and functions'. The other main teaching method

[90]John A. Ryle, 'The Future of Medical Education as Seen by a Teacher', *BMJ*, 6 September 1941, 323-7, 323, 325–7.
[91]Oswald, *op. cit.* (note 8), 302.
[92]'Interdepartmental Committee on Medical Schools: Memorandum of Evidence by the BMA', *BMJ*, 5 June 1943, 702–5, 703.
[93]'The Training of Doctors: Report by the Goodenough Committee', *BMJ*, 22 July 1944', 121–3, 121.
[94]Richard Boulton, 'Social Medicine and Sociology: The Productiveness of Antagonisms Arising from Maintaining Disciplinary Boundaries', *Social Theory and Health*, 15, 3 (2017), 241–60, 246.
[95]Oswald, *op. cit.* (note 8), passim.
[96]John A. Ryle, 'Education for Health', *The Lancet*, 3 June 1944, 713–5.

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was the case conference, where particular cases were discussed first by a clinician, and then by a medical social worker who had obtained information about the patient's domestic, economic, and occupational circumstances. As to the future, Birmingham and Edinburgh universities were establishing social medicine departments with, it was to be hoped, others following suit. Social and industrial medicine should 'counteract the old tendency to academic detachment from which medical research and teaching' had suffered too long. This issue of 'fundamental importance' should, therefore, proceed through the 'integration of clinical, scientific and social studies'.[97] The Institute's approach is captured by its 1947–48 teaching programme. Lectures included Ryle on 'The Meaning, Methods and Objectives of Social Medicine' and Russell on 'Vital Statistics and the Public Health'. Students were offered 'Field Visits', for example to the local car factory and, led by the Chief Sanitary Inspector, to 'Condemned properties, new housing estates etc'.[98]

In 1945, Ryle addressed the 'impersonal methods' of military and EMS hospitals. What was the physician's role, or medicine's purpose, if not to 'help the patient's mind and body in every possible way and at every stage of his illness?'. Patients were ill-served when left 'puzzled or in the dark', so it was a 'sad reflection' on clinical teaching's modern trajectory 'that institutional medicine' frequently degenerated 'into a kind of mechanical beside pathology'. The profession stood 'on the threshold of large reforms' in teaching and practice, so a new generation of teachers should remind their charges at every opportunity 'that "patients" are above all "persons" and not just "cases"'. Patients recovered more quickly, or accepted problems better, if they and their families were 'simply and clearly told what they most need to know'.[99]

Ryle revisited these ideas in his lecture on nosophobia. All doctors constantly missed 'opportunities of reassuring scared or anxious patients, and of removing or mitigating the associated symptoms which fears of disease, or its consequences create or aggravate'. But this did not figure prominently in medical education, notwithstanding its 'evident interest' for patients and their families. Doctors should have the 'courage' to 'accept clinical responsibilities' to impart 'courage' to their patients, for without 'a reasoned clarity in diagnosis and a reasoned hopefulness in prognosis we cannot properly counter fear'. Busy general practitioners and hospital doctors could not employ the 'more profound psychiatric methods', but time should always be made 'to examine carefully, to explain clearly, and to reassure as fully' as circumstances allowed.[100] In one of his last published letters, Ryle proposed that analysing patients' symptoms and history, clinical examination avoiding 'undue disturbance to the patient', and understanding the 'whole man' in his total environment would probably outweigh 'all the elaborate tools of the bedside pathologist'. Given the potential 'dangers' of 'over-mechanized' medicine, it would thus be a 'grave setback' if clinical specialists, bemused by a 'multiplicity of tests', ceased to be physicians.[101]

Health centres, conceived as integrating primary health and social care and promoted by reformers since the early twentieth century, had a particular role at all levels of medical education. In his 1942 address to MOsH, Ryle proposed that, under a state medical service, each general hospital be linked with a group of local health centres. Health education programmes 'would be shared between the staffs of both and with the public health department'. Given such developments, members of the public would talk with 'growing interest and pride … of "our centre" and "our hospital" served by "our doctors"', so expressing the 'ultimate fulfilment of the idea of communal responsibility for communal and individual health'.[102] In 1948, a few weeks before the NHS came into being, Ryle claimed health centres as an 'integral part' of public service medicine and medical education. Their staff should, therefore, 'hold status comparable with that of the teaching-hospital staffs'.[103]

[97]Ryle, *op. cit.* (note 52), 109, 110.

[98]Mellanby, PP/MEL/F.44, 'Programme of Lectures, Classes and Case-Conferences (Social Medicine and Public Health) for the Academic Year 1947–48'.

[99]John A. Ryle, letter, 'Telling the Patient', *BMJ*, 27 October 1945, 581.

[100]Ryle, *op. cit.* (note 48), 2, 16–17.

[101]John A. Ryle, letter, 'Man and the Machine', *BMJ*, 16 July 1949, 176.

[102]Ryle, *op. cit.* (note 70), 6.

[103]John A. Ryle, letter, 'Health Centres', *BMJ*, 22 May 1948, 1003.

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Health centres also had an educational function beyond professional training. Ryle's MPC memorandum argued that they should promote 'positive health instruction for the public'. Domiciliary practice should likewise be 'concerned with prevention and health instruction'.[104] In his 1942 SMA talk, he foresaw one of social medicine's most important long-term functions as popular education 'in the meaning and processes of health and the maintenance of healthy lives and homes', the only way to achieve 'the intimate understanding and the ultimate collaboration necessary for optimal results in national health planning'. The 'ideal', to which all must aspire, was 'more health rather than less disease for the community'.[105] In his 1943 *Manchester Guardian* article, meanwhile, Ryle claimed education as a further means of promoting infant and maternal welfare. He deprecated the 'cessation of school at 14' and the consequent shift into employment. This 'denied opportunity for learning the simple arts and disciplines of home and health and mothercraft'. What was also needed was encouraging and providing 'health education at all ages and for the population as a whole'.[106] Here, as elsewhere, Ryle promoted health, and health education, as a shared responsibility, a constituent of social citizenship.

Conclusion

As this article has shown, especially by way of previously unexamined sources, Ryle broadcast his vision of social medicine to lay and professional audiences in the two decades up to 1950. The space afforded by outlets such as *The BMJ*, his contributions to the non-medical press, diverse public engagement, and social medicine's inclusion in proposals for reconstructed medical education attest his impact. He had cause for optimism in that his historical analyses of the development of public health and of medical science suggested movement in the right direction, as did the apparent advance of 'scientific humanism'. But, thereafter, social medicine lost momentum. For Porter, it 'turned into something resembling an expanded concept of epidemiology', focusing on social behaviour rather than social structure.[107] Once again, this implies definitional challenges, openly acknowledged by Ryle himself and in turn highlighting two further, inter-related, issues.

First, there were institutional/medico-political problems. In 1995, Alice Stewart observed that Ryle's death also marked the beginning of the end for the Oxford Institute, with the University's medical faculty planning to abandon it as soon as Nuffield funding expired (although such grants were, generally, time limited). The Nuffield was, by this point, considering how best to allocate resources at a time of rising costs and questions over whether charitable bodies should continue to support existing academic activities.[108] This is not to say it abandoned its commitment to the social and biological sciences. But and partly bearing out Porter's point about a shifting focus, in 1954 the Department of Social and Preventive Medicine at Queen's, Belfast, gained funding for 'work on population genetics' – a project with no overtly social scientific input.[109]

Lewis proposes that social medicine, albeit a systematic attempt to re-envisage public health, failed to convince a broader professional audience while unwittingly threatening 'to weaken an already weak speciality further'. Its 'search for academic credibility' shifted it 'further away from a concern with health policy and social science', compounding the rift 'between teachers and practitioners in the field'.[110] And

[104]MPC, General Practice Committee Minutes, 14 January 1942, Memorandum by Professor John A. Ryle, 'A Whole-Time State Medical Service', 8, 12.

[105]Brynmor Jones, *op. cit.* (note 64), 324.

[106]Ryle, *op. cit.* (note 46), 4, 6.

[107]Porter, *op. cit.* (note 5), 153; *idem*, "From Social Structure to Social Behaviour in Britain after the Second World War', in Virginia Berridge and Stuart Blume (eds), *Poor Health: Social Inequality before and after the Black Report* (London: Frank Cass, 2003), 58–80.

[108]Alice Stewart, 'Learning from Ryle', *American Journal of Public Health*, 85, 10 (1995), 1460–1, 1460; 'Nuffield Foundation: Annual Report', *Nature*, 168, (1951), 648–9.

[109]'The Nuffield Foundation: Annual Report', *Nature*, 175 (1955), 374–6.

[110]Lewis *op.cit.* (note 29), 197, 213.

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when war's upheavals had passed, medical conservatism, signalled by the Goodenough Report's fate, reasserted itself. The NHS bedded down as a curative rather than preventive service. The stalling of plans for health centres, always viewed with suspicion by the medical establishment and seen as costly luxuries in a service already being challenged on financial grounds, exemplifies this trend. Among the few created in the NHS's first decade were 'The John Ryle Health Centre', opened in Nottingham, in 1952, and Manchester's Darbishire House which tried, unsuccessfully, to implement Ryle's ideas about 'observational research, teamwork, and education'.[111] Together, these factors help explain the stalled momentum of social medicine, at least as envisioned by Ryle.

Second, however, we also need to examine that vision more closely. In the late 1940s, Ryle and Russell investigated heart disease, already emerging as a major cause of death. They found it especially prevalent among the higher social classes where 'existing conditions of work' imposed strains 'which, when endured too long, are beyond physiological tolerance'. This needed to be addressed, although 'mental activity, unlike manual labour, cannot be readily limited by legislation or arrested by the clock'. Heart disease's upward trajectory would continue until 'social reorganization' promoted 'healthy living' and a 'deeper appreciation of … individual and social needs'.[112] A few years earlier, Ryle had written to Titmuss about his joint article with Morris on juvenile rheumatic heart disease, a piece he publicly praised. Nonetheless, the authors were 'flogging the poverty horse too hard', given 'serious local outbreaks of rheumatic fever in wealthy public schools and in the dormitories of naval training ships'. Oakley finds this evidence of Ryle's narrow, cautious approach.[113] What both cases illustrate is Ryle's vision of social medicine as concerned with the social determinants of health and his faith in survey methods, at least as he construed them. But they also demonstrate wariness about focusing exclusively on working-class health disadvantages. This returns us to Ryle's political coyness, manifested in his determination to distinguish social and socialised medicine, and is in marked contrast to Titmuss's and Morris's overtly political agenda.

Ryle's contemporaries perceptively picked up on such issues. Leff's portrayal of Ryle and his Institute was broadly sympathetic while drawing attention to shortcomings such as its tendency to 'collect statistics' and to select research topics randomly, with findings veering toward the academic and with no real base in medical practice or the local community. The 1952 *Lancet* eulogy for the Institute gently suggested that Ryle's work remained unfinished, a point made more forcibly by Galdston. The latter, bearing out Porter's argument, further claimed that some 'so-called' pioneers of social medicine were now 'sociologically, statistically, and epidemiologically oriented'. It was thus seen as clinical medicine supplemented by social scientific data and methods, a positive development without producing the sort of comprehensive, and transformative, programme envisaged by Ryle.[114]

Rosen was likewise not unsympathetic to Ryle while not pulling any punches. In his 1947 historical account he praised René Sand's contribution to social medicine, especially the 'central rôle that the concept of social class plays in his view'. Rosen followed this by an analysis of Britain, where studies of the 'social aspects of health and disease' had appeared in the 1930s. These included Titmuss's *Poverty and Population*, the subtitle of which, *A Factual Study of Contemporary Social Waste*, encapsulated the approach of such works and gave context to Ryle's work and the Institute's formation. Ryle's views were paramount, and 'models of clarity' compared to those employed by the recently founded *British Journal of Social Medicine*, but still suffered from definitional problems. Conceptually, British thinking was less advanced than the German authorities Rosen cited (a salutary reminder that although social medicine was strongly international, something of which Ryle strongly approved, individual nations were at

[111]'The John Ryle Health Centre', *The Lancet*, 8 November 1952, 931–2; Mark Perry, 'Academic General Practice in Manchester under the Early National Health Service: A Failed Experiment in Social Medicine', *Social History of Medicine*, 13, 1 (2000), 111–29, 113 and passim.

[112]John A. Ryle and W.T. Russell, 'The Natural History of Coronary Disease: A Clinical and Epidemiological Study', *British Heart Journal*, 11, 4 (1949), 370–89, 383, 389 and passim.

[113]Oakley, *op. cit.* (note 46), 185, 193, citing letter, 5 February 1944, Ryle to Titmuss.

[114]Galdston, *op. cit.* (note 13), 306.

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different stages of methodological development). Although British writers frequently used the word 'social', most of their studies still seemed 'clinical and statistical' – an obvious contrast with Sand's class analysis. It remained open whether such investigators would 'actually utilize sociological concepts and methods for the exploration of specific problems; and whether they will endeavour to see how the available knowledge of the social sciences can be put to use to improve health'. But it was significant that the Oxford Institute had 'a medical social worker on its staff, but no social scientist (sociologist, anthropologist or economist)'.[115] In short, Ryle's ambitions notwithstanding, British social medicine lacked definitional sharpness, had muddied the waters in respect of social class's role as a health determinant, and had employed medical science more systematically and effectively than social science.

Of course, social medicine in Britain did not die with Ryle. It found a home in, especially, its universities. But, in the short term at least, Ryle's particular vision failed. This failure was attributable to, paradoxically it might be argued, its radicalism alongside Ryle's apparent unwillingness fully to work through the fundamental questions he himself had helped formulate.

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[115]Rosen, *op.cit.* (note 3), 720, 722–5.

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