Corporate and technological changes in São Paulo medicine in 1930

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Abstract

Through the historical study of the corporate and technological changes experienced by doctors in São Paulo in the 1930s, we intend to identify how changes in the fields of equipment and knowledge came from the emergence of specialties, which led to corporate changes and rearrangements in the face of the dilemmas introduced by the Getúlio Vargas government and its policy of centralizing power. Connections are pointed out of a symbolic and representative order, backed by doctors considered 'old-school' and those that represented the 'new' times in medicine, evidencing the clashes between these currents vis-à-vis the specialization movement and particular landmarks in the history of São Paulo.

Keywords: history; São Paulo; São Paulo medicine; medical fraternity; medical specialties.

The current need to put into perspective historical studies concerning medicine and its technological developments acting on the social body has originated analytical perspectives regarding the conditions for the emergence of knowledge directed to explaining the social role in determining pathological processes and health practices. In the case of the history of medicine and public health, various works have been able to approach and reiterate understanding of the organization of medical institutions, the history of diseases and the technologies employed in health policies and so-called popular medicine. In this situation, history is able to understand health policies contextually and socially, comparing topics, methodologies, problems and alternatives that reclassify their interpretations (Hochman, Santos, Pires-Alves, 2004).

In the case of the so-called Paulista medicine (Paulista is a Brazilian adjective used to qualify something as related to the State of São Paulo – Translator's note), there has been a consistent output of historical studies directed to the scientific modifications experienced by its institutions in the first decades of republicanism and the role of its articulators as 'men of science'. However, as André Luiz Vieira de Campos (2006) has well noted, the Brazilian historiography concerned with matters relative to medicine and public health, despite being very numerous[1], "have concentrated their attention mainly on the 1870-1930 period", resulting in few "works that have had a go at the colonial or post-1930 periods". In the Paulista case in particular, the historiography still feels the lack of works focused on that decade[2] ones that identify the diverse changes experienced by its medical fraternity and its institutions. This is due to the fact that, at the political level, the period was marked by the weakening of state medical-sanitary institutions vis-à-vis the new government, a prime example being the dismantling of the state sanitary project, fragmented in the 1940s into various sections without any articulation or rationality of expenditures (Campos, 2006, p.69). The time was also marked by changes in political power, configuring a certain 'suppression' of the 'founding history' of Paulista medicine and its expressions. Emblematic is the case of Doctor Emílio Ribas, whose peers, according to Borges Vieira (1937), dubbed him The Forgotten One in 1937: "From then to now, the restitution of his merits continues to be largely in the debit column, there having been few homages paid to his memory. The public in general still does not know him, many of his achievements are still neglected or ignored by the poorly informed authorities" (p.269). To counter this state of affairs, traditions have been created (Hobsbawm, Ranger, 1997) to restore Ribas to his place as a 'sanitary pioneer': "He wasn't the first, nor the last, from whom an ungrateful nation has withheld praise. One day, the accounts will be fully settled!" (Vieira, 1937, p.296).

The internal changes in the medical fraternity put the final touches to this context. With the arrival of new health practice requirements, specialties became consolidated, leading to confrontation and disputes in establishing professional hierarchies and their fields of action. The analysts are still largely unaware of such issues, despite the studies on medicine and health in São Paulo in the 1930s. Some substantial lacunas are still perceptible regarding the understanding of its public policy models, the areas encompassed by these actions and the place occupied by the fraternity based on its 'Paulista talents.[3] Therein lies the challenge of this reflection.

The Paulista medical fraternity in the 1930s

The Paulista medical elites responsible for (re)writing the 'history of Brazilian medicine' beginning in 1930 identified three stages in the scientific and corporate 'evolution'. The first, which can be defined as the 'clinical', was related to the "first two medical colleges founded in the country at the same time, 1832, in Rio de Janeiro and Bahia during the Empire" (Prado, 1947, p.7). The second moment, known as the 'experimental', was marked by the emergence of the Instituto Butantan and Manguinhos at the turn of the 20th century; and finally, the 'university period', a product resulting from the new medical teaching structure introduced in 1931 (p.7).

This division of the history of Brazilian medicine, so habituated to the new Getúlio Vargas contours during the 30s and 40s, encompasses, however, complex dimensions regarding the historical perspective, since the period was profoundly marked by corporate and political events mingled with regional struggles, but obscured by the unitary defense of the Estado Novo.[4] In São Paulo, we find the medical fraternity in the 1910s and 1920s involved in its professional, scholastic and political organization, together with sanitation needs in the main cities and interior (Hochman, 1998). For Castro Santos (2004, p.262), a "hardly orthodox" positivism helped accomplish a "scientific and intellectual environment frankly favorable to the development of health". At the level of medical and political representations, it was stated that whoever arrived on Paulista soil would soon realize the particularities racially personified in its inhabitants, materialized in the medical-sanitary capacity to make São Paulo the stage for national hygiene and health. (Mota, 2005).

Between 1920 and 1930, a series of corporate transformations was initiated related to the formation of the doctor and his specialties, giving increasingly more importance to clinical thought in medical and public health questions. Several aspects marked this change. Identified with the new delineations received from the Rockefeller Foundation, in turned based on the Johns Hopkins Hygiene School, the new teaching model proclaims, on Paulista soil: limiting the number of students, obligatory full time instruction, the organization of disciplines into a system of departments and adding clinical instruction to the hospital-school structure (Marinho, 2001, p.65). The change also corresponded to the passing of the European hegemony in medical education to the American influence, a change that represented, at this political level, a reorientation of the alignment in relation to the Vargas federal government.

According to Ayres (1997, p.181), this time was marked and influenced by the medicalization of epidemiology and public health in the United States, the medical fraternity having fought against any integration of the medical and public hygiene fields, struggling to keep in their hands control over any agenda connected with medical matters and those of public health considered to fall within the medical domain. The author emphasized that "state intervention in the health field would only be tolerable within the limited scope of environmental sanitation, public education and some non-assistance measures to control transmittable diseases" (p.182). In São Paulo, however, despite these positions also being present, differences identified during this period between the Faculdade de Medicina and Instituto de Higiene proclaimed the clash between those professionals.

In this respect, actions were implemented that modified the medical-sanitary structure then in effect, considered an important pillar of power of the dominant oligarchical elite (Campos, 2002, p.54-55), at the same time that an appropriate system of ideas was sought for this new professional configuration. As Merhy noted (1992), supported by the conceptual benchmarks of health research developed in the 1980s by Mendes-Gonçalves (1994), the door was opened for a verticalized administration of health services, established by specific problems and using all the instruments of curative medicine campaigns and sanitary education. This restructuring provided a great impulse to both the practice of medicine, the 'new' doctor gaining increased status as a scientist vis-à-vis the 'old' practices, and to hygiene, based on the ideas of racial improvement through strategic eugenics (Mota, 2003; Mota, Santos, in the preface).

The arrival of Getúlio Vargas to power brought a new set of circumstances to this movement, implemented beginning in 1934 with the appointment of Gustavo Capanema to the Ministry of Education and Public Health (Mesp) and the reform transition of January 13, 1937. Removing the autonomy of state medical and scientific institutions, now subordinated to federal institutions, such as the National Department of Health and Medical-Social Assistance, became radicalized with the creation of Mesp, which was expected to articulate policies that would enable constructing a governmental apparatus that would be able to act throughout Brazil, coordinating actions at the federal, state and municipal levels (Hochman, Fonseca, 2000). According to Braga and Paula (1981), this centralizing movement initiated the constitution of a national public health policy, albeit limited, until the developmentalist wave of the 50s.

The Capanema administration divided Brazilian territory into eight regions, each with a Federal Health Office, the foremost objective being the establishment of national authority through political and administrative centralization capable of coordinating, executing and inspecting health actions in the states. Such an undertaking produced a health services structure that was repeated in diverse sectors, forming a network of services. For example, the Health Centers, conceived by Geraldo de Paula Souza (1939) as a sanitary action based on the American proposal of integral preventive medicine, were considered by Paula Souza himself to have been diverted from his original project and transformed into mere medical assistance, making his proposal a dead letter, suggests Merhy (1992, p.112).

Even though preserving assistance in the Health Centers, in place of Paula Souza's proposal, other actions and measures arose[5] that, in addition to dismantling the bureaucratic legacy, defined:

> In the capital, the city would be divided into five zones, each of them entrusted to a health chief in charge of a Center. Functions would be grouped there, ranging from residential policing to dispensary activities. We had already calculated the number of doctors then available in the Capital to distribute to the centers or specialized departments. Each Center in the capital would have two doctors for policing...reducible to one doctor, plus a doctor for pre-natal service, two for infant hygiene, one for school hygiene, one for tuberculosis, one for venereal diseases and one for periodical medical examinations or substitutions (Vieira, 1932, p.506).

When evaluating the São Paulo Public Health Department at the conference held on July 27, 1931, Doctor Francisco Borges Vieira[6], who was in charge of the institution during the intervention government of Laudo Camargo, was already talking about these institutional changes[7], which consolidated intervention actions effected by 'new' figures in Paulista politics and altered the power game in the 1930s. Among these personages, Adhemar de Barros was among the politicians who won favor with the central government, obtaining the federal intervention trusteeship for the State during the 1938-1941 period.[8] Among his political acts at that time, he replaced all of the mayors in the interior of the state and got into conflict with many personalities of public life in São Paulo, forcing the exile of such figures as Júlio de Mesquita Filho, a prominent Paulista newspaper owner and politician. A doctor graduated by the Universidade do Brazil with specialization at the Instituto Oswaldo Cruz, the interventor used professional prerogatives to back up the interventionist policy in the medical and health area and confront his opponents. This was the so-called 'Butantan case', when Adhemar, still a deputy, brought accusations in the Legislative Assembly against Doctor Afrânio Amaral, director of the institute from 1936 to 1937. In the opinion of Ibañez and others (2006, p.78), this dissension would confirm the fragility of the state political universe during the period and the importance, even in open conflict, of certain members of the medical fraternity in the political articulations of the State. Such an institutional crisis would reflect the search for a new identity related to the political party disputes that preceded instauration of the Estado Novo in 1937.

Adhemar never failed to justify his actions to the medical fraternity as being for the good of São Paulo, being remembered and honored for his representative institutions. In the awarding of degrees for the Class of 1940, the Faculdade de Medicina of the Universidade de São Paulo invited him to be a speaker. Taking advantage of this opportunity, Adhemar made a balance sheet of what had existed in the state before he came to occupy the interventionship (Barros, 1940). In his opinion, eight points illustrated the historical "Paulista medical drama": (1) the state's precarious demographic situation of the state, with a significant increase in maternal and infant morality; (2) the numerous maladies of an endemic nature that afflicted the rural regions; (3) tuberculosis, with an annual death rate of nine thousand and 41 thousand sick; (4) cancer and the lack of any specific hospital assistance; (5) the mentally ill, who were incarcerated in jails, "as if we still lived in the age of medieval darkness" (p.204); (6) the formation of doctors, in its multiple aspects; (7) poorly equipped and distributed hospital assistance, as well as emergency treatment, considered extremely poor; and (8) medical instruction that did not have a Clinical Hospital (p.204).

The list of "government achievements" presented was a response to part of the Paulista medical fraternity, formerly so praised and now disenfranchised and criticized as inefficient and low in quality. To do so, the interventor listed the changes brought about by his administration, beginning with the reformation and centralization of the Sanitary Service by "creating, expanding and modernizing its services in the State Health Department" (Barros, 1940, p.207). Through the Hygiene Service, the School Health Service Board declared it would care for children from a hygienic point of view, as well as their physical and intellectual potentials, a clear vocation for the new model, which emphasized infant

assistance and combating tuberculosis. The number of beds in the Hospital Miguel Pereira and the Leonor Mendes de Barros sanitarium reserved for tubercular minors was significantly increased, according to the interventor (p.204). Moving on to the measures would stanch the increase in high maternal and infant mortalities and institute a eugenics project for the people, he dealt with childcare and its prophylactic actions, such as reform and expansion of the Childcare Service. To combat cancer, the federal government had already provided land on which a cancer hospital would be built and, for the mentally ill, 600 places were added to the capacity of the Hospital do Juqueri, making a total of 6,700 beds.

A brief assessment of the changes, presented and praised as responses to redress the repressed demands in the medical and sanitary areas, is capable of detecting some practical limitations regarding the progress of these institutions, as well as their area of influence. State sanitation works related to health in the interior, for example, illustrate this gap between their statements, with their strong nationalist campaign content, and the achievements listed. In the case of malaria, the proposals involved prophylaxis and anti-malaria measures such as specialized assistance, sanitary hydrographic works and epidemiological research related to entomology, serology and hydrobiology. Nevertheless, studying the technological organization of malaria control between 1930 and 1950, Barata (1993) shows that, despite the creation of the Prophylaxis and Impaludism Inspectorship in 1933, 60% of the Paulista municipalities were classified as malarial and only six had diagnostic and treatment posts for the disease. When attacked or threatened, certain municipalities succeeded in imposing the power of their local forces to institute the medical-sanitary improvements desired. Such state regionalization indicates that, in the agricultural border zones and certain areas in transition, "services are installed in those areas where the more consolidated economic interests determine the definition of priorities" (p.52). One thus notes that the alterations listed suffered, in many cases, from the same 'diagnostic strategies' that the first medical-sanitary organizations in the state produced.

Thus, in areas 'impervious' to capitalism –as was the glaring case of the Ribeira Valley and other places in the interior that had been economically penetrated, but whose local elites had no power to interfere in the State's public policies – the lack of public health actions and even of doctors was evident. If there were actions undertaken in these abandoned 'portions' of the state of São Paulo, the 1930s and 1940s did not see any of them.

In this context, another axis of changes invaded the medical profession, beginning with clinical specialties, and, in the midst of this Paulista regional complexity, the gap that separated the 'old' and the 'new' placed these two groups in conflict, signaling to those that insisted on remaining tied to the medical thinking of the past that times were different. More than this: the category must take into consideration the fact that to 'be Paulista' was to assume a quick and constant attitude, always moving toward progress and power.

Redefinitions of the medical profession: specialties on the agenda

Liberal medicine entered into decline in the 1930s, characterized by Schraiber (1993, 1997) as a means of turning out work on an individual basis in a private office. In the

1930-1960 period, this standard will be replaced by another means of producing medical work in society, which, according to the author, consists of technological medicine, with progressively technically based and gradually business oriented medical assistance arrangements. These became consolidated after 1960 with the growing establishment in Brazil of public or private medical assistance companies. Medicine, thought until then to be a practice exercised 'person to person', begins to contradict the transition context, in other words, with the configuration of the new structural arrangements between the State, the political system and civilian society (Belmartino et al., 1988, p.14-15).

Starr (1991, p.282) recalls that the salaried employment of doctors, emblematic of these transformations in liberal medicine, took place in Europe and the United States at the end of the 19th century and the first decades of the 20th, when charitable help for the 'poor and indigent' began to be phased out by the State. Medical work was thus being incorporated into the new system, not only as a liberal profession (19th century), but also as a salaried person, within the scope of the state strategy to guarantee 'the worker' the right to that benefit. Medicine had already affirmed its labor dimension through the purchase of services, but expanded it to salaried medical work itself, previously rejected, mainly by doctors with a generalist education.

In the Brazilian case, such changes were tied to centralization of the health policy by the national State, as well as the elaboration and development of social welfare medicine, starting with the creation of the Institutos de Aposentadoria e Pensões (IAPs), instituting the initial demand for medical service expenses, directed essentially to urban centers. (Braga, Paula, 1981, p.71). In Schraiber's reflections (1993), these would be changes subsequently recorded in diverse ways in the regional labor markets of Brazil and that "came about as a function of the different form of organizing the production of medical assistance services, starting with the process of extending it to the population after the 1930s" (p.137). A result of the social and economic model that was then adopted, the practice of liberal medicine felt the impact of these alterations, especially in São Paulo, the Brazilian industrial center.

The deep extent of these changes was felt at the 1st Brazilian Medical Syndicate Congress, held between July 19 and 23, 1931, where the topics were almost entirely devoted to medical specialization, the state absorption of its institutions and, consequently, the struggle of the fraternity to protect its professionals in the face of these dilemmas. The topics considered were the code of medical deontology and professional ethics, professional freedom, foreign doctors (qualification and clinical practice), medical-social assistance and welfare, accidents and professional illnesses, medical insurance, the abuse of official medical services, charlatanism, faith healing and the dishonest practice of medicine, medical and pharmaceutical advertisements, medical fees, the concept of the specialty, the plethora of doctors, State medicine, professional secrecy and professional fraternization (Notes and information..., 1931).

Given the situation unfolding for the profession, so divergent from times past, the feeling of some doctors in São Paulo was one of pessimism. That context led to a "corporate crisis", which, for Rubião Meira (1932, p.52), could easily be identified in the indifference to the 'old doctors': "A superior being, with an almost divine mission, he has found nothing but weak support from those who need his activity, from those who seek his

knowledge". For him, once his mission was over, he would rarely win the friendship of his patients and very few recognized the value of his science. This venting was essentially directed to the new physicians, who, in the face of scientific, corporate and political changes, gave little or no credit to the origins of the fraternity, creating a watershed between the medicine of old, full of heroics and acts of grandeur, and the one then being instituted, cruel and distanced from its 'original history'.

An exemplary case would be that of the São Paulo Society of Medicine and Surgery, where one saw that the chairs disputed by the novices were abandoned after their election. The 'old' doctors repeated their protests, because the sessions in which matters of interest to the fraternity should be discussed were suspended due to the disinterest of the newly elected. According to André Dreyfus (1932, p.83), prior to joining the Society, "they excel in their zeal for the meetings, they adore the Society with all the fervor of the young". As soon as they are received into the ranks, however, they disappear and become as rare as the others. Doctors who had just graduated saw this theme from another angle, characterizing the order as one that should break with its retrograde and senseless past and open itself to the new times heralded:

> formerly, the school was dreary. The dreary physiognomies of our student antecedents also wandered through the corridors. The monotonous classes filled the inexperienced freshman with fear, the veterans filled them with tedium. The professors, learned university doctors, dictated scientific and regulatory laws from their lecterns. Life went on, went on, the school was improving, coffee fell, the new rich emerged, the petite bourgeoisie now wanted to study medicine etc. etc... great defeats, great beer parties and a new life began for the medical student. They only spoke of reforms. Everything must be reformed, from the statutes to the furniture. The fact is that light began to shine in the anxious little heads of the future doctors. (Editorial, 1939).

According to a study by Pereira Neto (2001, p.120), in 1922 at the National Congress of Practitioners, the first public disputes between the "old generalist" doctors and the "new specialists" could already be seen. This new context made explicit the changes from a fully knowledgeable professional to the new professional, more technical and specific, suited to the technical assistance demands for access to medical assistance in urban and rural centers, with new ways of producing social services. (Schraiber, 1993, p.135). In the Paulista case, specialties were required as a catalyst of policies in the fields of research, medical practice and organizations of a prophylactic nature; ultimately, the institutional and official structure they wished to implant required specialized professionals (Marinho, 2001), able to occupy and manage them, which, in turn, required that a new type of medical formation be consolidated in college and other courses (Fonseca, 2000, p.395).

As for medical instruction, those responsible for it considered two subjects relevant and worthy of attention. The first had to do with the uncontrolled proliferation of doctors and medical colleges, a ban being requested on new institutions, through the so-called *numerus clausus*, and, the second, restricting professional practice by foreigners, "urging, therefore, legislative intervention to mitigate foreign infiltration", in the words of Doctor André Dreyfus, cited in Fonseca (2000, p.190):

> Predicting and preventing for the future. Predicting, taking from the present the lesson present day reality acclaims, and preventing, promulgating effective preventive measures. Among them, some are in the government sphere, the doctors only having to indicate to the State through their associations and fraternal organizations the best way to implement them in laws: more energetic regulation of the practice of the profession, rational socialization and distribution of medical functions, guarantees against foreign invasion, others concerning the class itself – raising their moral and intellectual level - through rigorous teaching methods and strict observance of professional ethics.

Thus, in 1932, through Decree 5.351, the Faculdade de Medicina underwent a comprehensive reorganization process, requiring it to adopt the Francisco Campos Reform, which, among its prerogatives, controlled and centralized higher education at the federal government level and, at the same time, attempted to homogenize teaching, specifying the reorganization and parity of private teaching institutions (Silva, 2003, p.25). Beyond the university chairs themselves, other reforms were made in the field of specialties pertinent to medical work. They received new contours, with more specific technologies and objectives, and required special education for professionals involved with health demands coming from the countryside and the city.

Upon reorganizing the Instituto de Higiene de São Paulo in 1931, the interventor, João Alberto Lins de Barros, introduced the Public Health course as an innovation in medical specialization. The basic material proposed by the future sanitarist brought particularities that very closely approximated the changes made by epidemiologists in health departments in the United States. There the minimum requisites were: graduation in medicine and clinical training in a hospital; one year of basic education in sanitary engineering, bacteriology and immunology in public health, zoology, statistics, public health administration and epidemiology (Ayres, 1997, p.181). The sanitarist was expected to have in his résumé, besides a medical degree, education in the following: bacteriology and immunology, sanitary chemistry, zoology, statistics, sanitary engineering, epidemiology, physiology applied to hygiene, dietary nutrition and bromatology, the pathology of avoidable diseases, sanitary administration and national and comparative sanitary legislation (São Paulo, April 1, 1931). Special instruction was also proposed in disciplines exclusively related to hygiene: pre-natal hygiene, infant hygiene, pre-school hygiene, mental hygiene, rural hygiene, personal hygiene and heredity, eugenics and social problems (p. 15).

If there were similarities between the formation of an American epidemiologist and a Brazilian sanitarist, there were also differences. The medical fraternity in the United States fought to remove from its field any non-medical professional involved in medicine or health, such as statisticians and biologists. In São Paulo, the fight was enjoined between the doctors themselves and their specialties, one that gave general practitioners greater power to act in the field, leaving the sanitarist with no room to apply his specialty. Looking at the changes experienced by the Health Centers, Paula Souza (1939) observed that, contrary to what he had dreamed of, public health matters had been removed from the province of the medical sanitarist and transferred to the general practitioner. He believed this created some "confusion" that was prejudicial to the daily life of the Centers, more precisely the failure to consult "professional" sanitarists: the opinion sought "is generally that of the general practitioner who renders services in the Health Centers, where, lacking sanitarists,

management is also the responsibility of general practitioners" (p.14). This way of organizing services, without meeting the demands for modernization of hygiene proclaimed by Paula Souza, would be transforming these centers into "simple outpatient clinics for medical assistance". As a result, he asked for special space for the sanitarist to practice, whose demarcation he considered a priority for the work to proceed: "The Health Center should exist, prosper and develop, but in the shade of the professional sanitarist's guidance. We need more of them in the health services to make them more efficient and offer protection for private clinic practice by the competent" (p.16).

It should be noted that, despite being unaware of the historical option that he would be practicing, Paula Souza understood the new profession as a preventive medical modernization based on the medicalization of hygiene in the environment, almost in the same sense as clinical intervention in individual medicine, in other words, through a 'sanitary education'. This way of conceiving of the sanitarist's profession introduces, on the one hand, the sanitary education tool and, on the other, encompasses, within Brazilian limits, the American hygiene literature, whose liberal character, as well pointed out by Donnangelo (1975, p.130) and Arouca (2003), would end up provoking tension in the Brazilian political context. This new fragmented and interdependent field of knowledge became an arena of hot dispute. Even though the discourses rehashed the idea of the doctor being a professional able to develop any area of medicine,

> the pressure for medical assistance was an inexorable fact that, as a legitimate form of individual welfare and the construction of citizenship, immediately concerned the obligations of the State. Through a set of conditions... medical assistance was transformed into one of the spheres of practice mostly closely related to the material, social and political development and stability of modern nations (Ayres, 1997, p.183).

In a conjuncture in which increasingly more room was opened for the incorporation of medical work by the State, each specific area fought for its autonomy and legitimacy and sought to respond to external resistances to a field of medicine that itself was still in construction. Bourdieu (2004, p.21-22) should be recalled here, one for whom the scientific field is a force field and a field of battle to transform it. While the transformations were evident, it should be understood how this 'struggle in the field' was conducted by professionals and what were the results of each of these oppositions. Using this bias, both Flamínio Fávero's definition (1938, p.13) of the medical field and his defense of a specific area, legal medicine, are interesting:

> Medicine is not limited to studying diseases in all its modalities and establishing the various therapeutic processes, guiding them in order to return the sick individual to perfect health, as *curative medicine* does or hopes to do. Its job is also to prevent injuries to the health of the isolated individual and, more so, individuals as a whole, constituted in groupings, explaining the problems of health protection, the business of hygiene, to public administrators. Finally, it has a mission to guide legislators and magistrates in the preparation and application of civil and criminal laws collectively, as *legal medicine* does (italics in the original).

In fact, this reasoning sought to legitimize and defend Fávero's specialty, legal medicine, arguing its compatibility with the new medical technologies and its importance for other

areas, such as hygiene (Fávero, 1938, p.15).[9] Nevertheless, this defense of legal medicine with the specificities of a medical specialty gradually became the target of tensions created by the doctors in the area themselves. The apprehension concerning the area's disuniting effects arose together with medical-legal expansionism itself (Ferla, 2005, p.61). What was seen was the attempt to find, in that specific knowledge, adjustments capable of legitimizing its knowledge as 'medical science'.

Equal efforts were made in other fields of knowledge, as for example, surgery, about which Almeida Prado categorically affirmed (1938, p.188) that its evolution would be characterized by the tendency to fit within broader medical molds, since it was being merged with increasingly profound complexity into general practice. According to Prado, to be a specialist was to elevate oneself from a previous status – that of a general and liberal practitioner in his "domain of interventions"- to "more scientific and individualized" action. The practitioner of armed interventions, "the surgeon of the past, has given way to the surgeon of today, i.e. the technician dressed as a doctor" (p.139). This had consequences in the fraternity, for the master and his famous 'scalpel strike, with a loss of prestige, but it ensured technical precision in intelligence and scientific rigor in surgery: "the inquiry into the state of major organic functions; vigilance of the gastro-intestinal tract; verifications regarding blood balance conditions, the pH balance, the uretic content; biochemical exploration of the organs; all this requires the surgeon to have a solid grounding in clinical medicine and represents a reliable guarantee of his professional efficiency (p.188).

This corporate and technological reconfiguration was felt by many professionals, mainly the generalists, who were unable to adapt themselves to the new centralizing and social welfare demands, particularly salaried employment and the nationalization of their occupation, which led many to professional defeat. In his reflection on the topic, André Dreyfus (1932) observed that the changes surrounding the doctor's work were profound and capable of extinguishing the past, taking the contemporary doctor's perception in a different direction:

> medicine's growing relationships with the State regarding its role as a preventive body and hygiene orientater; its interference in pedagogy and the technical organization of proletarian labor; its forced participation in works created and maintained by public authorities (hospitals, sanitariums, dispensaries); its incontestable sociological and eugenics function – all this, at the same time that it has increasingly expanded its scope of action, is also diverting its traditionally autonomous and individualist purpose to *socialization*, if not *functionalization* (italics in the original).

The great increase in the number of professionals in the large urban centers and their competing among themselves for positions has to be considered. The doctors feared that the situation of excess production of professionals would, based on an "ineluctable economic law, devalue the product's quotation in the professional market, in the words, blunt perhaps, but picturesque, of an newspaper writer" (Dreyfus, 1932, p.178). Many doctors assessed that this paradoxical context between the numerical explosion of professionals and their poor distribution throughout the country had expanded, when all is said and done, the room for the so-called popular health practices, which, despite being utterly rejected, continued to reign in the interior of the entire state.[10] According to Dreyfus, it was due to

ignorance that this population of the interior 'prefers a thousand times to replace a doctor's care with that of the herbal healer, the faith healer or the fetishist, an argument that, seen from a particular point of view, is understandable, but groundless from a more general viewpoint" (p.185). As a result, an increased presence of the medical contingent was expected in those areas precisely to "change what goes on in these regions, when, driven by necessity, they spread to the far-flung corners of the country and demystify these environments subjected to ignorance and the bad faith of alien explorers" (p.185).

With that scenario of so many imbalances, the doctor would become like any other proletariat, losing the emblems that distinguish him from other professionals – thus thought Vicente Marcílio (1929) when he stated that 'Medical proletarization" was a fact of reality. The medical body of the hospitals, hospices, laboratories, dispensaries and sanitariums, formed by doctors, surgeons, radiologists, mid-wives and nurses, would be nothing more than "a set of real workers, with rights and obligations like any industrial company", but with a difference: no labor protection regarding work accidents (p.3-4). For Marcílio, even the doctors who had room to do exercise their occupation were subject to accidents, from the slightest to the most serious, occasioned by infections, radiodermatitis, aggressions and disasters. He argued, in fact, using "case histories" involving Paulista doctors:

> 1º) A certain doctor, well known in Jaú, having operated on a case of suppurating appendicitis, was nearing the end of the operation when the scalpel slipped and produced a superficial wound on his forearm. He disinfected it with antiseptics, but it did no good, because afterwards a serious septicemia infection appeared that claimed him victim; 2º) the first and much missed director of this school, the unforgettable Professor Arnaldo V. de Carvalho, dedicated as he was to his profession, despite all the rigorous aseptic care taken, suffered a serious infection that killed him; 3º) Alexandrino Pedroso, deeply knowledgeable in microbiology, a professor of that chair in our college who spent most of the day in his laboratory, was another grand figure who fell at his post of honor, victim of his great love for science (p. 26-27).

Given these and other victims listed, he requested approval of the projects presented by Messrs. Jorge de Moraes and Amaury de Medeiros for the legal benefits offered to factory works for job-related accidents to be extended to doctors. Stalled in the National Congress, this dispute was taken up by the Society of Medicine and Surgery, formalizing a Syndicate of Doctors:

> thus, due to the initiative of Professor Flamínio Fávero and afterwards of the commission comprised of Professors Flamínio Fávero, Mario Ottoni de Rezende, Antonio Carlos Pacheco e Silva, A. Brasiliense and others, they undertook to found in S. Paulo a Medical Syndicate, which, in article 24, line C of its By-Laws, treated the issue of professional risk as follows: it will fight for the passage of a law regulating the issue of professional risk in labor accidents to extend the legislation to doctors (Marcílio, 1929, p.39-40).

Final considerations

As we have been able to follow, the 1930s brought significant corporate changes to the medical field, starting with the Vargas centralization of public health policies and its search for control over the working class in urban centers, instituting social welfare medicine.

In São Paulo, in particular, given the state medical-sanitary independence in effect and its urban-industrial dimensions, the changes were intense, running up against medical education and the liberal nature of its work. For these professionals, the new working conditions sounded a warning. Their argument was that a group of professionals who were beginning to get old, many of whom had not achieved the purchasing power that would ensure their future, would be abandoned to chance like "corporate indigents", having their offices emptied because of the medical assistance provided by the IAPs. Such was the state of things that Professor Flamínio Fávero found when he surveyed the living conditions of various doctors, having noted at the time: "within a society where what counts most is an activity providing immediate gratification", the rapid pace of the new era did not allow them to plant sturdy oaks satisfactorily: "These are fast-growing vegetable times, the very meal tomorrow expects" (*São Paulo Médico*, 1931, p.135).

Even if the vaunted proletarization of medical work had not occurred – since the medical fraternity held in its hands the means of production and reproduction of that work – innovative technologies invaded the field foretelling changes, accompanied by the conflict between the specialties and the emergence of new professions, such as nurses and other health professionals at the technical level. Dissemination of the idea of doctors relegated to oblivion and misery was one of the ways used to unite a medical fraternity increasingly more disperse and hierarchical. For that reason, the Brazilian Medical Syndicate ended up creating 'the class's greatest dream"; the Doctor's Home. In a pronouncement transmitted in São Paulo by Rádio Educadora, Hélion Povoa (1932, p.68) praised the initiative and sought donations:

> it should belong to all of us, even though it only receives in its comforting bosom those toppled by the misfortune of destitution in the dawning or zenith of life, but especially in the somber darkness of old age. Educated in the cruelest of schools, where on the same coarse bed or the same cold table the poor or rich fall, whether Hercules or pygmies, we should not be surprised by the ambushes of bad luck. In this home, our home, we must save a corner for the day when the world refuses us a spot of tea. Helping construct the doctor's home in cooperation with the Brazilian Medical Syndicate is looking out for the Brazilian medical class: give us your support, my dear colleagues, doctors everywhere in Brazil!

NOTES

[1] Examples of works on the history of medicine and public health in São Paulo, developed in the 1970s and 1980s are Mesgravis, 1976; Bertolli Filho, 1986; Castro Santos, 1987; and Gambeta, 1988.

[2] Concerning the political and symbolic configurations of São Paulo in the 1930s, see Ferreira, Luca, Iokoi, 1999; Ferreti, 2004; and Glezer, 2007.

[3] A pioneering study on the relationship between Paulista medicine and the construction of Brazilian nationality in the First Republic is that of Castro Santos (1987). Also along these lines and in that period, Mota (2005) contemplates the way in which the symbolisms surrounding 'Paulistanity' invaded the medical discourse, which interwove the 'natural' success of the medical fraternity and its institutions with the 'mythological' and 'racial' origins of São Paulo.

[4] For a broader understanding of the policy developed in the so-called Vargas Era, see Gomes, 1996, 2000; and Ferreira, Delgado, 2003.

[5] We are here dealing with the 'permanently vertical specialized' model, in contrast to the 'permanently horizontal', both formulated by Merhy (1992, p.117).

[6] A graduate of the Faculdade de Medicina e Cirurgia de São Paulo, Borges Vieira received in 1918, together with Geraldo Paula Souza, a grant from the Rockefeller Foundation to study at Johns Hopkins University.

[7] Regarding his time in the Department, Borges Vieira (1932, p.501) indicates: "Depending on how the matter was resolved, our stay with the Director of the Department would only be for a few days, since they were thinking of closing it down, which in fact happened on August 3, re-establishing the position of General Director of the Sanitary Service, where we began to work, no longer connected with the Hygiene Institute or Butantan and the Psychopathic Assistance, which once again became autonomous sections within the Department of Health and Public Sanitation".

[8] In 1941 Adhemar de Barros was fired from his position. With the Constitution of 1946 and the state elections of 1947, he was re-elected governor of the state by the Partido Social Progressista (PSP) (Progressive Social Party) with the support of the Partido Comunista Brasileiro (PCB).

[9] The period between the wars was substantive for legitimization of legal medicine as a science, through social and institutional recognition (Ferla, 2005).

[10] For Carvalho (2005), there was allegedly in São Paulo a repressive fence around popular medical practices considered criminal. They were exemplified as faith healing, the illegal practice of medicine and dentistry, exploitation of public credulity, etc. Only in the 1980s was there a resurgence – and even incorporation – of popular medical practice into developed therapeutics.

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