THE DEVELOPMENT OF MEDICAL ETHICS – A SOCIOLOGICAL ANALYSIS

by

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It is a curious fact that despite the rapidly growing volume of literature on the professions, little work has been done by sociologists on the development of professional ethics. This omission becomes doubly curious when one considers the central importance attributed to professional ethics in much of the literature on professions; given this situation one can hardly aspire to an adequate sociological analysis of the development of professional occupations which does not include an analysis of the development of professional ethics. This paper aims, in a modest way, to help fill this gap by analysing the origins and early development of modern medical ethics.

The most famous of all codes of medical ethics is probably the Hippocratic Oath, which Edelstein dates from the fourth century B.C.[1] From time to time, slightly modified forms of the oath were developed, for example to allow Christians to take what was originally a pagan oath, and although there was no body which enforced the ethical rules contained in the Hippocratic Oath, it appears to have had some influence on medical practice. Thus Chauncey D. Leake has pointed out that prior to the end of the eighteenth century, "the medical profession tried generally to handle its ethical problems on the basis of the Greek tradition of good taste and personal honor".[2] However, if we wish to understand the development of specifically modern codes of medical ethics, we must look not to ancient Greece, but to nineteenth-century England, and in particular, to the work of Thomas Percival, whose *Medical ethics*, published in 1803, marks an important break-point between ancient and modern medical ethics. As Leake has pointed out, it was Percival who, more than any other person, effected the "transition from the broad principles of Greek medical ethics to the current complicated system".[3]

This view of Percival as the founder of modern codes of medical ethics is shared by most medical men. Thus Forbes has referred to Percival's work as a "prominent landmark in the progress and evolution of medical ethics", and adds that "No later work has modified in any material degree the precepts and practice defined by Percival for the conduct of a physician".[4] Barton has written that Percival "compiled the first modern code of medical ethics",[5] while McConaghey comments that the "rules of conduct of modern times stem from the small book published in 1803 by Thomas Percival".[6]

While it is difficult to over-estimate the importance of Percival's book, it would be quite wrong to see it, in an almost asocial sense, purely as the work of a gifted individual, for Percival's work is simply the most famous of a number of publications by

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English practitioners in the first half of the nineteenth century, all of which indicate a major concern with ethical problems in the practice of medicine. These included W. O. Porter's *Medical science and ethicks*,[7] published in 1837, and Abraham Banks' *Medical etiquette*,[8] published in 1839. This concern with ethical problems also found expression in articles and editorials on medical ethics in all the major medical periodicals, as well as in the considerable number of letters from readers dealing with similar problems. Finally, mention must be made of associations, like the Manchester Medico-Ethical Association,[9] which were founded specifically to deal with ethical problems, and of the development of medico-ethical committees in medical associations founded for more general purposes, such as the British Medical Association, which set up its own medico-ethical committee in 1853.[10]

Thus Percival was not working alone, for his concern with medico-ethical problems was shared by many of his contemporaries. Our problem, then, is to explain *why* practitioners in England were concerned with medico-ethical problems at this time. In general terms, the attempt to formulate codes of professional ethics, and to establish institutions to enforce those codes, can be seen as an attempt, by professional men themselves, to cope with certain recurrent problems with which they are faced in the practice of their profession. These problems are not individual problems, but problems which are shared by many members of the occupational group in question. Thus, to ask why English practitioners were concerned with medical ethics at this time, is to ask what sort of problems they habitually faced in the practice of medicine. It is the task of this paper to answer this question.

Before, however, we come to this question, we must briefly analyse a precondition, though by no means a sufficient condition, for the development of professional ethics, namely the breakdown of the patronage system. The attempt to formulate and enforce a code of professional ethics represents a development towards what has been termed "colleague control"—that is, a form of social control in which the professional activities of practitioners are regulated by the actions and sentiments of their professional colleagues. Yet colleague control is only one of a variety of forms of occupational control, and prior to the nineteenth century it was by no means the dominant form of control of professional activities. Thus the eighteenth century was an age of patronage, and patronage typically gives rise to a structure not of colleague control, but of client control. Under patronage the aristocratic and wealthy client is the dominant partner in the client-practitioner relationship; the client, by virtue of the wider social bases of his power, is able to define both his own needs, and the manner in which those needs are to be met. Moreover, the ties which bind the practitioner to his patron or patrons are those of loyalty and personal subservience, and as Carr-Saunders and Wilson have pointed out, "Men who are in that condition of personal subservience do not easily associate with their fellows. Association might seem to indicate a striving towards an independence that would be incompatible with the relation of client to patron".[11] A similar argument has been more recently expressed by Johnson, who points out that patronage is associated with a fragmented, locally oriented occupational group. Under patronage, the practitioner defers to and identifies with his patron or patrons, rather than with his professional colleagues. Under these conditions, the solidarity of the occupational group is relatively under-developed,

while the "authority of the patron reduces the clear function of ethics and autonomous disciplinary procedures".[12]

It is clear, then, that a well-developed patronage system is inimical to the development of any form of colleague control, including professional ethics. The breakdown of the patronage system, concomitant with the widening of the market for medical services in the nineteenth century, can thus be regarded as a precondition for the development of codes of medical ethics. It is, however, proper to regard this as a precondition, rather than as a direct cause of the development of medical ethics, for it does not, of itself, answer the question of why medical practitioners were concerned with medico-ethical problems at this time. For an answer to this question, we must look elsewhere.

Traditionally, sociologists have argued that the development of professional ethics must be seen within the context of practitioner-client relationships. In 1933, Carr-Saunders and Wilson suggested that "Just as the public may fail to distinguish between competent and incompetent, so it may fail to distinguish between honourable and dishonourable practitioners. Therefore the competent and honourable practitioners are moved mutually to guarantee not only their competence but also their honour. Hence the formulation of ethical codes."[13] A few years later, T. H. Marshall argued that "Ethical codes are based on the belief that between professional and client there is a relationship of trust, and between buyer and seller there is not."[14] Since the time that Carr-Saunders and Wilson and Marshall wrote, the suggestion that practitioner-client relationships are crucial to an understanding of professional ethics has become almost a sociological orthodoxy. Characteristically, those who pursue this line of argument suggest that for a variety of reasons, but primarily because of his ignorance, the client is unable to judge the quality of the professional services which he receives. Consequently, the client is very vulnerable to exploitation by the unscrupulous practitioner. The development of professional ethics is seen as a response to this problem of social control. Thus the professional group itself undertakes to guarantee the integrity of its members by the development and enforcement of codes of professional ethics. In this way, the risk of exploitation of the client is minimized.[15] Specifically in relation to medical ethics, this type of explanation seems to be shared by most medical historians and, not surprisingly, by medical practitioners themselves.

This approach, however, has been developed in the absence of any detailed empirical investigation of the development of codes of professional ethics. How well, then, does this approach enable us to understand the development of modern medical ethics? If we examine Percival's *Medical ethics* carefully, we find little evidence that Percival was concerned primarily with ethical problems in the doctor-patient relationship. If we exclude Percival's last chapter, which is on medical jurisprudence rather than medical ethics, we find that out of a total of forty-eight pages, only half-a-dozen or so are devoted to a consideration of ethical problems in the doctor-patient relationship. Moreover, his advice to practitioners on how to behave towards patients is, for the most part, of a highly general kind, very much in keeping with the Greek tradition; there is thus nothing specifically modern about it. Thus Percival advises practitioners to "unite tenderness with steadiness", and "condescension with authority".[16] All cases should be treated "with attention, steadiness and humanity".[17]

Percival gives little advice on how to cope with specific problems in the doctor-patient relationship, although he does suggest that there should be no discussion of a case before the patient,[18] that practitioners should observe "secrecy and delicacy" with female patients,[19] and that the "familiar and confidential intercourse, to which the faculty are admitted in their professional visits, should be used with discretion and with the most scrupulous regard to fidelity and honour".[20]

If, however, comparatively little space is given to a consideration of ethical problems in doctor-patient relationships, a great deal of space is devoted to the establishment of a set of rules for regulating the relationship *between* practitioners. Moreover, the advice which Percival gives to practitioners in this context is much more concrete, and more detailed. Consider, for example, his advice concerning the conduct of consultations. "In consultations on medical cases", he says, "the junior physician present should deliver his opinion first, and the others in the progressive order of their seniority. The same order should be observed in chirurgical cases."[21] Even more detailed is his advice on consultations between physicians and surgeons. Thus, "In consultations on mixed cases, the junior surgeon should deliver his opinion first, and his brethren afterwards in succession, according to progressive seniority. The junior physician present should deliver his opinion after the senior surgeon and the other physicians in the order above prescribed."[22] Moreover, to resolve any uncertainty arising in situations where the lines of seniority are not clearly defined, Percival even sets out a method for assessing the relative seniority of practitioners engaged in consultation with each other.[23]

The fact that Percival's book is concerned primarily with regulating relationships between practitioners has been clearly pointed out by Leake, who makes a distinction between medical etiquette and medical ethics. Medical etiquette, he suggests, "is concerned with the conduct of physicians toward each other, and embodies the tenets of professional courtesy. Medical ethics should be concerned with the ultimate consequences of the conduct of physicians toward their individual patients and toward society as a whole."[24] He notes that "The term 'medical ethics', introduced by Percival, is really a misnomer . . . it refers chiefly to the rules of etiquette developed in the profession to regulate the professional contacts of its members *with each other*".[25] Nor is this surprising, for Percival's work was, in fact, written specifically in order to resolve a purely intra-professional dispute. In 1789, an epidemic of typhoid or typhus taxed the capacity of the Manchester Infirmary, and the trustees decided to double the staff. The surgeons and physicians already on the staff took this as a reflection upon their efforts, and resigned. In the confusion attending the change of staff, there was apparently a good deal of friction between the practitioners attached to the hospital, and Percival, who was physician extraordinary to the infirmary, was asked to draw up a "scheme of professional conduct relative to hospitals and other medical charities". The result was a small book which was printed for private distribution in 1794, and which appeared in a revised form in 1803 as Percival's *Medical ethics*.[26] Leake has pointed out that "The circumstances under which Percival's 'Code' was written, made it necessary for him to place considerable emphasis on medical etiquette",[27] while Lester King has observed that the book was designed "specifically to establish greater harmony among the physicians who had the care

of the indigent sick, and was in no sense an attempt to explore any vague ethical generalities".[28]

Despite the special circumstances under which Percival wrote, his book was by no means unique, in terms of the kinds of problems with which it dealt, for Percival's concern to regulate relationships between practitioners was shared by many of his contemporaries. Thus Abraham Banks' *Medical etiquette*[29] was, as the title suggests, concerned almost entirely with intra-professional relationships. The only point at which the doctor-patient relationship becomes problematic for Banks is when one practitioner is called in to attend the patient of another practitioner, a situation which only becomes problematic because another practitioner is involved in the management of the case. A similar story is told by the letters to the *Lancet,* in which allegations of unprofessional behaviour focus almost entirely around the conduct of consultations and the poaching by one practitioner of the patients of another.[30] Another major intra-professional problem, which was also dealt with by Banks[31] concerned the division of fees in cases where the regular practitioner was unable to attend and another practitioner was called in. In 1845, the *Lancet* reported that a meeting had been called in London to establish some rules governing fee-splitting in such cases. The *Lancet* commented that "Some general arrangements of this nature had long been needed" and it went on to express the hope that such an arrangement would help remove "the stigma cast upon the profession, that it displayed no more cohesion than a 'rope of sand'."[32]

In fact, virtually all of the literature from this period supports the idea that relationships between practitioners were much more sensitive, and much more in need of regulation, than were relationships between practitioners and their patients. Occasionally, the tensions between practitioners gave rise to open hostilities. Thus in 1837, the *Lancet* carried an editorial on a dispute between certain medical practitioners in Newport and Monmouth. In the course of the dispute, which was publicized in the *Monmouthshire Merlin* for 25 November, the practitioners involved took to "placarding" one another, that is distributing bills critical of their opponents.[33] In 1845, the *Lancet* devoted another editorial to a conflict between two practitioners in Frome, Somerset. This dispute, like many others at the time, arose as a result of a consultation between the two practitioners, both of whom had published pamphlets criticizing the other. The *Lancet* observed that one of the practitioners "heaps insult upon insult on his opponent, on his opponent's brother—whose part in the case was merely that of a spectator—and even attacks the entire medical profession of Frome".[34]

These well-publicized conflicts merely represented the tip of the iceberg however, for conflicts between practitioners were endemic at this time, and it seems to have been appreciated by practitioners themselves that the major problems with which they had to contend arose from the internal divisions and tensions within the profession. Thus Abraham Banks referred to the "prevalence of illiberality in country towns and villages; the jealousy existing between individual practitioners, who frequently, under the mask of candour and professed friendship, undermine each other's reputation, and never lose a chance of sinking one another in public estimation, when this can be done with seeming good grace and kindness".[35] That relationships between provincial practitioners were often strained will come as no surprise

to those who are familiar with Trollope's *Doctor Thorne*;[36] it is, however, difficult to see how they could be more strained than those between London practitioners when the *Lancet* could refer to hospital consultants, and to those who controlled the Royal Colleges as "crafty, intriguing, corrupt, avaricious, cowardly, plundering, rapacious, soul-betraying, dirty-minded BATS".[37] Clearly, however, Banks had this kind of intra-professional conflict very much in his mind; his object, he said, was "to promote concord and harmony amongst the several branches of the profession".[38] A similar point was made two years earlier by W. O. Porter, in his *Medical science and ethicks*, when he called upon doctors to follow the golden rule, "Do unto all men as you would that they should do unto you".[39] He hoped that we "should not then be exposed to feel, or witness, or even hear of those feuds, which sometimes arise between members of the profession, so injurious to the interests of all concerned, and so derogatory to that high character, which it is our duty to preserve, and should be our chief aim to raise in the estimation of the public".[40]

This same point was repeated over and over again by those writing on medical ethics. Thus in 1845, a correspondent of the *Lancet* called for the introduction of "a standard or rule to guide doctors in their professional activities". However, he went on in a somewhat despondent manner, "Or, is this subject too delicate, and must we continue to live on, hoping for better feelings and deportment in those who have hardly a fair word to use for their brother? Perhaps it is doubtful, after all, whether any set of rules would unite a body so disaffected as ours".[41] Perhaps most telling, however, are the comments of the author of a paper on medical ethics which was published in the *London Medical Gazette*. The writer, W. B. Kesteven, pointed to the "urgent need of a generally acknowledged principle whereon to base the rules of medical ethics", and claimed that "it is doubtless the want of some such principle that permits the jealousies, bickerings, and calumnies which distress and divide the different branches and interests of the profession".[42] He then went on to ask "Is it not an unenviable paradoxical notoriety, that a profession pre-eminently benevolent and . . . eleemosynary to all beyond its own immediate sphere, should towards its own members be proverbially uncharitable and litigious? Alas! will the time never be that men shall apply to its members the eulogium so unwittingly extorted from the pagans of old, 'See how these Christians love one another?' Or rather, how long shall it be that the world shall continue to say, 'See how these doctors hate one another?"[43]

This argument is particularly telling, because it indicates quite unambiguously that relationships between doctors and the wider society, including patients, were characterized by benevolence and charity on the part of practitioners. The same point was made in an editorial in the *Lancet* in 1842,[44] and indeed, it seems to have been a point on which the medical profession prided itself. The everyday problems facing medical practitioners, it is clear, arose not in their relationships with their patients, but in their relationships with their professional colleagues, relationships which all too frequently were characterized by tensions, by hostilities, by accusations and counter-accusations. The development of medical ethics, it is suggested, can best be understood as an attempt to regulate these tension-ridden relationships so as to reduce the amount of potentially very damaging intra-professional conflict.

In order to understand the reasons for this endemic conflict within the medical profession, we must have some understanding of the rapidly changing structure of medical practice at this time. Traditionally the law had recognized only three types of medical practitioners: physicians, surgeons, and apothecaries. These three groups were organized in a hierarchical structure, with physicians forming the "first class of medical practitioner in rank and legal pre-eminence".[45] By the Statute of 32 Henry 8, physicians were allowed to practise physic in all its branches, among which surgery was included. However, the disdain which physicians, as a body of learned men, felt for manual work, had led to a contraction in their duties, and by the eighteenth century, the practice of the physician was held to be properly confined to prescribing of drugs to be compounded by the apothecary, and in superintending operations performed by surgeons in order to prescribe what was necessary to the general health of the patient, or to counteract any internal disease. The controlling body for physicians was the Royal College of Physicians of London, a small and exclusive body, very conscious of the necessity to maintain the high status which physicians had long enjoyed.

In sharp contrast to physicians, surgeons had long been regarded as craftsmen rather than gentlemen. The surgeons had been united with the barbers in the Company of Barber-Surgeons until 1745, in which year they formed a separate organization, the Company of Surgeons, which subsequently became the Royal College of Surgeons of London in 1800. The proper sphere of practice of the surgeon was held to consist generally in the cure of all outward diseases, and in the use of surgical instruments in all cases where this was necessary.[46]

The lowest order of the medical profession, the apothecaries, had been organized in the Society of Apothecaries since 1617. The charter of the Society required seven years' apprenticeship to a member as an essential qualification for admission to the freedom of the Company, and stated that at the end of seven years "every such apprentice . . . shall be examined, proved, and tried concerning the preparing, dispensing, handling, commixing and compounding of medicines".[47] However, by the early part of the eighteenth century, the apothecaries had successfully grafted medical on to pharmaceutical practice, and had won legal recognition of their right to "administer medicine of their own authority, and without the advice of a physician".[48]

This tripartite structure was enshrined not only in the internal institutional structure of the profession—in the sense that there were separate licensing bodies for physicians, for surgeons and for apothecaries—but also in the legal system. Thus the "orders" of the profession were hierarchically ranked, and each grade of practitioner had privileges which were legally defined. The general concept of the qualified or registered practitioner had no place in English law prior to the Medical Act of 1858; instead there were separate laws relating to physicians, to surgeons, and to apothecaries.

If, however, this tripartite structure was more or less clear in formal terms, it had become, by the beginning of the nineteenth century, anything but clear in practice. The social and economic changes associated with the agricultural and industrial revolutions—too complex to be gone into here—had not only expanded the demand for medical care, but had also created demands for a new type of medical care. Under the impact of these new demands the divisions between physicians, surgeons, and

apothecaries were steadily breaking down. Thus, from 1750 onwards, a rapidly growing number of practitioners were combining the practice of medicine, surgery, midwifery and pharmacy to form a quite new professional role, that of the general practitioner. By the 1830s, general practitioners were by far the most numerous class of medical men, probably providing some ninety per cent of the qualified medical care in England. Numerous witnesses who gave evidence before the Select Committees of both 1834[49] and 1847–48[50] testified to the fact that there were hardly any practitioners, even in London, who could confine their practice to pure medicine or surgery.[51]

Not all medical men were engaged primarily in general practice, however, for the growth of hospitals in the eighteenth and nineteenth centuries had given rise to a much smaller, but very important, class of consulting physicians and surgeons who owed their positions as consultants primarily to their hospital appointments.[52] Thus in the period 1750–1850 the traditional tripartite structure was being steadily eroded and replaced by the emergence of the modern structure of medical practice, based on the differentiation between general practitioners and the hospital-based consultants.

While the traditional tripartite structure was clearly breaking down, however, an institutional structure appropriate to this new professional differentiation was slow in developing. This resulted in a very confused situation, in which definitions of roles and statuses within the medical profession were very unclear. As a correspondent of the *Lancet* pointed out in 1841, "Everything connected with our profession is, at present, in a state of disorder and uncertainty; its laws are in abeyance; and young men, about to commence their medical studies, are quite at a loss what to expect, or what plan of education to pursue".[53] The medical profession in the first half of the nineteenth century was, as Leake has bluntly but accurately characterized it, "a mess", and within this ambiguous and fluid situation, different types of practitioners "jockeyed for positions of prestige and power".[54]

This jockeying for position was related to the prevailing confusion surrounding the division of labour within the profession, a problem which was intimately related to the different statuses attributed to different kinds of medical work. Thus the role of the general practitioner cut across the traditional tripartite division of labour, since it necessarily combined the practice of medicine, surgery, pharmacy, and midwifery. A number of practitioners however—particularly the consulting physicians and surgeons—were bitterly opposed to the incorporation of what they regarded as purely manual or trading activities into the doctor's role, for they feared that such a development threatened the high status which physicians had long enjoyed, and which surgeons had recently attained. Thus the Royal Colleges of Physicians and Surgeons, which were dominated by the consultants, adopted a variety of policies designed to maintain the purity of medicine and surgery undiluted by manual and trading operations, and to stem the rise of the general practitioner. Among other things, they refused to broaden the scope of their examinations to cover anything other than pure medicine and surgery respectively,[55] and to allow general practitioners on to their governing councils.[56] The general practitioners in turn resented what they saw as an attempt to deny them their proper place within the profession and to condemn their characteristic mode of earning a livelihood as a low-status

medical occupation, unfit for gentlemen. From the second half of the eighteenth century the general practitioners launched a campaign for the democratic reform of the medical corporations, for the reform of medical education and licensing, for the abolition of the divisions between physicians, surgeons, and apothecaries, and for the recognition of general practice as a legitimate and honourable professional activity.[57] This campaign, which lasted for a hundred years, was bitterly fought, and gave rise to extremes of vituperation and personal insult, in which the *Lancet* in particular excelled, and occasionally it gave rise to the use of physical violence by one section of the profession against another.[58] The widely held picture of a profession as a harmonious community is not one which can readily be applied to the medical profession in the nineteenth century.

This analysis provides a major key to the understanding of why ill feeling and disharmony so often characterized relationships between practitioners. It also helps us to understand why the problem of defining what kinds of activities should be undertaken by what kinds of practitioners figured prominently in the literature on medical ethics. Thus only in these terms, it is suggested, can we understand Percival's lengthy discussion of the relationships which ought to prevail between the different "grades" of practitioners. Of Percival's three chapters on medical ethics, the whole of the third chapter is devoted to a discussion "Of the Conduct of Physicians towards Apothecaries", while other statements on the relationships between physicians, surgeons and apothecaries are scattered liberally throughout his work. Thus in his advice on the conduct of mixed consultations, cited earlier, Percival showed a clear understanding of the nice status distinctions between physicians and surgeons in his recommendation that the most junior physician present should deliver his opinion after the most senior surgeon had delivered his.

On issues of this kind, Percival was a conservative—according to Sir George Clark, "the best conservative opinion" of his time[59]—and accordingly he advised his fellow practitioners to maintain the traditional division of labour within the profession. Thus in his chapter on hospitals, he advised that "A proper discrimination being established, in all hospitals between the medical and chirurgical cases, it should be faithfully adhered to by the physicians and surgeons on the admission of patients".[60] Similarly, in the chapter on private practice, he recommended that "In large and opulent towns the distinction between the provinces of physic and surgery should be steadily maintained. This distinction is sanctioned both by reason and experience.... Experience has fully evinced the benefits of the discrimination recommended, which is established in every well regulated hospital, and is thus expressly authorized by the faculty themselves and by those who have the best opportunities of judging of the proper application of the healing art. No physician or surgeon, therefore, should adopt more than one denomination, or assume any rank or privileges different from those of his order."[61] Similarly, in his chapter on the relationships between physicians and apothecaries, he suggests that physicians should refuse a request to visit the patients of an apothecary, in the latter's absence. "Physicians", he argued, "are the only proper substitutes for physicians; surgeons for surgeons; and apothecaries for apothecaries."[62] Thus Percival tried to present guidelines which would prevent the continual disputes over the division of labour within the profession;

his solution, as we have seen, was to call for the maintenance of the traditional divisions within the profession.

While most practitioners seem to have agreed that the breakdown of the traditional tripartite division of labour was a major cause of the jealousies and tensions within the profession, few were willing to go along with Percival's conservative remedy. The radicals' position was clearly set out in a long paper on medical ethics by Thomas Laycock, which was published anonymously in the *British and Foreign Medico-Chirurgical Review* in 1848. Laycock pointed out that the profession "seems little better than a chaos; the whole mass is upheaving; decomposition and recomposition are going on; but we can discern no great principles by which coherence and strength may be given to the discordant elements. It is quite impossible that the intelligent lay public will notice the professional desire for organization and legislation, so long as the impelling motives are nothing more dignified than sectional interests, grade prejudices, or interested clamours in a pecuniary sense".[63] "How", he asked, "can members of Parliament and the educated classes esteem a profession, the members of which mutually disparage each other?"[64] Laycock then went on to examine the squabbles over the division of labour within the profession. "All bodies of men" he argued, "are intolerant of any departure from principles and practices that have become conventional. Although such departure may have nothing whatever in it morally wrong, yet it is visited 'with the utmost rigour of the law'—that may have been conventionally established. Thus physicians fully engaged in practice will bitterly regard the young physician who, feeling the pressure of the *res augusta domi*, may exercise any surgical talent he may possess, or who, suspecting that his medicamina are not well compounded, or of a spurious quality, may look to the manufacture of his powder, or point his own guns."[65] He pointed out that even though all types of practitioners co-operated harmoniously in organizations like the Royal Medico-Chirurgical Society, the educational institutions continued to "raise their Shibboleth before the public, before Parliament, and in the profession, and establish their differences where there is hardly any distinction". The leading men in the College of Surgeons treated medical cases as frequently as surgical ones. "To all purposes, and in every way, the surgeon is a physician, with the ability to operate chirurgically superadded to his medical acquirements, and is conventionally permitted to operate, prescribe, and receive his fee, so long as he calls himself 'surgeon'. But led him add M.D. to his name, and conventionalism forthwith binds up his right hand, severs him from his College, and circumscribes the sphere of his usefulness." Laycock added that "if it could be proved that this line of demarcation, already obliterated in the voluntary associations, is of any use whatever to either the profession or the public when drawn between two classes of practitioners, in which the difference of education and attainments is *now* at least really but nominal, we would acquiesce at once in the arrangement. But it has yet to be shown that a union of these two educational institutions, and a reorganisation on a broad base of ethical principles, would either render the surgeon less skillful, or the physician less educated or intellectual. The whole matter is indeed hardly capable of serious argument." Thus Laycock called for the abolition of those professional divisions which Percival had defended in 1803. Only by taking such a step, argued Laycock, could the intra-

professional squabbling and bickering be ended. Thus he concluded his paper by calling on enlightened provincial practitioners to place the organization of the profession on "its proper basis", or else the profession would remain "as it is—a chaos of conflicting elements".[66]

Shortly afterwards, the *Lancet* gave Laycock's paper its "warmest approbation". Quoting extensively from the article, the *Lancet* said "there are no passages in the article . . . with which we more cordially agree than those which describe the unworthy jealousies which rise between some among the different classes of the profession, when any man dares to step out of his proper line; when the physician or surgeon, for instance, trenches upon the province of the general practitioner; when the general practitioner aspires to the work of the surgeon or physician; or when the physician and surgeon dare to defy artificial distinctions, and pass from one department to the other." The *Lancet* added "how constantly have we dwelt on the meretricious separation, the unworthy caste-division, which seeks to make the highest surgeon lower than the physician, and the highest general practitioner lower than both".[67] The *Lancet,* of course, had, since its foundation in 1823, campaigned consistently for the abolition of the tripartite structure, and by the middle of the century there was widespread agreement amongst doctors that there could be no end to the disharmony and tensions within the profession as long as the tripartite structure remained. It is hardly surprising that this issue should have figured prominently in the literature on medical ethics.

As the tripartite structure was steadily being eroded, so the modern structure of medical practice, based on the differentiation between consultants and general practitioners, was beginning to emerge; indeed, these were, in reality, different aspects of the same process. But just as the breakdown of the tripartite structure gave rise to problems, so too did the emergence of the consultant-general practitioner relationship. As the hospitals developed, so they gave rise to a class of consulting physicians and surgeons, and the practice of calling in a consultant to help in the management of particularly difficult or ambiguous cases became increasingly common. Relationships between general practitioners and consultants were frequently characterized by hostilities and tensions however, for both roles were, in a real sense, new roles, and as such, they had not yet, at this period, become as clearly differentiated and institutionalized as they are today. In particular, there was one critical area of overlap between the role of the consultant and the role of the general practitioner, an area of overlap which not only differentiates the nineteenth-century consultant from the present-day consultant, but which was also at the root of much of the conflict which characterized consultations in the nineteenth century.

This critical area of overlap arose because consultants did not then—as they do now—confine their practice to consulting work, but also normally acted as general practitioners to small numbers of wealthy clients. In addition there were a large number of practitioners—particularly in the provinces, where consulting work was normally less readily available—who derived the major part of their income from general practice, but who also occasionally acted as consultants within their own locality. The result was that consultations were normally held between two practitioners, both of whom, to some extent, were in general practice; thus there was a real

element of competition involved, particularly for wealthier clients. Within this situation, mutual suspicion and hostility between consultants and general practitioners were common. Allegations by general practitioners that consultants were trying to poach their patients, either by calling on the patient a second time without the knowledge of the regular attendant, or by implicitly or explicitly criticizing the therapy recommended by the latter, were common. From the 1830s onwards, the *Lancet* published numerous letters from practitioners alledging breaches of professional etiquette, the most common complaints being those which related to the conduct of consultations and the poaching of patients. In 1849, W. B. Kesteven referred to the "censurable condemnation of a professional brother, whether of a higher or lower grade, by looks, gestures, innuendos, etc. For example, a physician called in consultation takes occasion in the absence of the general practitioner to hint that a different treatment should have been adopted; or by indirect means, such as *friendly* visits, etc., supplants the ordinary attendant, or destroys his patient's confidence".[68] In 1854, the *Association Medical Journal,* in reply to a correspondent who complained of the conduct of a consultant, agreed that it was easy for a consultant to:

> Convey a censure in a frown,
> And wink a reputation down.

The *Association Medical Journal* went on to point out that "extreme watchfulness and honesty of act and feeling are essential requisites in this class of practitioners".[69]

The conflict between general practitioners and consultants—which was in effect a demarcation dispute—smouldered on throughout the nineteenth century, and towards the end of the century, in 1886, the lines of conflict were more clearly articulated than ever before with the foundation of the Association of General Practitioners. The Association, which was founded with the aim of forcing consultants to confine their activities to consulting practice, would have nothing to do with "so-called consultants who practised as general practitioners. . . . It will not seek to discredit them, nor will its members refuse to meet them when required to do so; but it will exert all its individual and collective influence in favour of those who act as consultants as the term is understood by this Association".[70]

Given this situation, it is hardly surprising that a number of writers, from Percival onwards, should see consultations and the poaching of patients as major areas requiring regulation by a code of medical ethics. Percival's advice on these points is quite detailed. Thus we have seen that Percival not only lays down the order in which parties to a consultation should deliver their opinion, but also suggests a way of calculating the seniority of the respective practitioners involved. Punctuality should be observed in consultations, and "No visits should be made but in concert, or by mutual agreement".[71] When consultations are held, "no rivalship or jealousy should be indulged. Candour, probity and all due respect should be exercised towards the physician or surgeon first engaged."[72] "Officious interference, in a case under the charge of another, should be carefully avoided."[73] If a practitioner is called to a patient under the care of another practitioner, he should always observe "the utmost delicacy towards the interest and character of the professional gentleman, previously connected with the family".[74] The practitioner should "interfere no farther than is

absolutely necessary with the general plan of the treatment; to assume no further direction, unless it be expressly desired; and, in this case, to request an immediate consultation with the practitioner antecedently employed."[75] Abraham Banks deals with many similar problems, advising consultants not to call on patients without the general practitioner being present,[76] giving advice on how to divide the fee when two practitioners consult,[77] on how to act when a second party is called in to decide upon the treatment of another practitioner,[78] and on what to do (and what not to do) when one practitioner is sent for to the patient of another practitioner.[79] In W. Fraser's "Queries in medical ethics", a series of questions and answers on ethical problems published in the *London Medical Gazette* in 1849, no less than fourteen of the twenty-seven queries deal with consultations, and with taking over the management of a case from another practitioner.[80]

Medical practitioners, it is clear, were no more given than any other section of the educated classes to the consideration of abstract philosophical principles. Rather, their concern with medical ethics was a practical concern, arising from certain recurrent problems with which they were faced in the day-to-day practice of their profession. In this paper it has been suggested that these practical problems arose primarily within the context of relationships *between* practitioners, as a result of certain structural tensions within the profession. The commonly held view that professional ethics develop primarily in order to regulate relationships between practitioners and their clients finds little support from an analysis of nineteenth-century writings on medical ethics, in which ethical problems in the doctor-patient relationship occupy only a minor place.

It is not suggested, of course, that an understanding of practitioner-patient relationships is irrelevant to an understanding of medical ethics, for there are clearly passages in Percival's work, as in the work of other writers, which relate to the doctor-patient relationship. What is suggested is that the importance of the doctor-patient relationship for an understanding of medical ethics has been very considerably overstated, and that the development of medical ethics may be much more closely related to the need to regulate relationships between practitioners than has commonly been held.

Nor is it claimed that this analysis is equally applicable to the development of codes of professional ethics in all professional occupations at all times, for the significance of colleague relationships, as well as the potentiality for intra-professional conflict, are likely to vary according to different structural conditions. Nevertheless, the analysis might well be applicable to other occupations which emerged as modern professions in the nineteenth century, for the changing pattern of demand for professional services during that period produced some similar changes, resulting in similar tensions, within other professional groups.[81] However, the structural conditions under which many new occupations—including many para-medical occupations—are today striving for professional status, are quite different, and it would be foolish to expect them to follow the characteristic nineteenth-century pattern of professional development.

However, the case of medicine is an important test case, if only because the medical profession has so frequently been used as the prototypical profession, on the basis of

which a number of models of the professions have been constructed by sociologists. The conventional explanation of the development of professional ethics is not valid, it is suggested, even for the prototypical profession, and it is perhaps time that sociologists took a harder, more critical look at the conditions under which professional ethics develop, and at the functions which they perform. It would seem that for too long sociologists have accepted on trust the bland assurances of the professionals themselves that codes of ethics develop purely in order to protect clients. If sociology is, as Berger suggests, the art of mistrust,[82] then it is perhaps time that we were a little less trusting.

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74. Ibid., p. 98.
75. Ibid., p. 106.
76. Banks, op. cit., note 8 above, p. 10.
77. Ibid., pp. 5–9.
78. Ibid., pp. 54–59.
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81. The most striking similarities are, perhaps, to be found in the legal profession in the nineteenth century. As Carr-Saunders and Wilson have noted, the development of both professions "was anything but smooth. . . . On reflection it appears that what happened in both cases was the early segregation of practitioners, advocates, and physicians, whose function at a later date was realized to be specialist. But the associations of these specialists, having attained great power and prestige, attempted to inhibit the development of general practitioners of law and medicine of whose services the public had need. When they could not prevent their appearance, they tried to keep them subservient, and the history of both professions is largely concerned with the problems so brought about." See Carr-Saunders and Wilson, op. cit., note 11 above, p. 304. In the legal profession the general practitioners were, of course, solicitors.
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