

**Beyond Professional Self-Interest: Medical Ethics and the Disciplinary
Function of the General Medical Council of the United Kingdom, 1858-1914**

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Summary: Traditional historiography tends to draw a negative picture of British doctors' ethics during the long nineteenth century. Medical professional ethics of this period has been described as self-serving and as a tool to monopolize the healthcare market. In this paper I attempt to challenge this rather one-sided view by looking into evidence for the practice of medical ethics, not just its normative texts. Focusing on the disciplinary function of the General Medical Council and discussing a variety of its cases, from fraudulent registration, sexual misconduct and breach of confidence to negligence, covering of unqualified assistants and advertising, I argue that nineteenth-century medical ethics aimed at supporting the interests of patients and of the public at large as well as the reputation of the profession.

Keywords: medical ethics, medical discipline, General Medical Council, medical profession, United Kingdom

Introduction

Medical ethics in Britain during the long nineteenth century tends to have a bad name among scholars. Jeffrey Berlant and Ivan Waddington have claimed that doctors' ethics in that period was self-serving, aiming more at supporting the interests of the profession than at protecting patients. In particular they have suggested that regular doctors used ethics as a strategy to demarcate themselves from unlicensed and unorthodox practitioners and as an instrument to mitigate competition within their profession by focusing on rules for maintaining smooth intra-professional relationships between physicians, surgeons and apothecaries, and between consultants and general practitioners. Furthermore, medical ethics was characterised as a trust-inducing device vis-à-vis the public and as a tool for monopolisation of the healthcare market.¹ In addition, bioethicists Laurence McCullough and Robert Veatch have suggested that after promising beginnings in the late eighteenth century, British medical ethics lost its way: while the well-known lectures of Edinburgh professor of medicine John Gregory on the duties and qualifications of a physician of 1772 had been influenced by contemporary Scottish Common Sense philosophy, so the

¹ Jeffrey Lionel Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* (Berkeley: University of California Press, 1975), 68-81; Ivan Waddington, 'The Development of Medical Ethics – A Sociological Analysis', *Medical History*, 1975, 19, 36-51; idem, *The Medical Profession in the Industrial Revolution* (Dublin: Gill and Macmillan, 1984), 153-175. See also Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), 59-62.

argument goes, subsequent writers on medical ethics got too much embroiled in intra-professional issues and lost the connection with moral philosophy.²

Only occasionally this negative picture of medical ethics in the long nineteenth-century has been qualified in some respects. For example, reinterpreting Thomas Percival's influential text *Medical Ethics* of 1803, which had been blamed, since Chauncey Leake's edition of 1927, for having promoted an intra-professional focus over attention to doctor-patient relations, Robert Baker has identified elements in it that seem to reflect contemporary social contract theory.³ Duncan Wilson has recently highlighted English physician Jukes Styrap, author of a late nineteenth-century code of medical ethics, as an example of a writer who emphasized a link between professional and public interest by arguing that patients were best served by trusting a unified medical profession that was clearly distinct from 'tradesmen and quacks'.⁴ Similarly, Andrew Morrice has

² John Gregory, *Lectures on the Duties and Qualifications of a Physician* (London: W. Strahan and T. Cadell, 1772); Laurence B. McCullough, *John Gregory and the Invention of Professional Medical Ethics and the Profession of Medicine* (Dordrecht: Kluwer Academic Publishers, 1998); Robert M. Veatch, *Disrupted Dialogue: Medical Ethics and the Collapse of Physician-Humanist Communication (1770-1980)* (New York: Oxford University Press, 2005). See also Lisbeth Haakonssen, *Medicine and Morals in the Enlightenment: John Gregory, Thomas Percival and Benjamin Rush* (Amsterdam: Rodopi, 1997).

³ Robert Baker, 'Deciphering Percival's Code', in idem, Dorothy Porter and Roy Porter, eds, *The Codification of Medical Morality*, vol. 1: *Medical Ethics and Etiquette in the Eighteenth Century* (Dordrecht: Kluwer Academic Publishers, 1993), 179-211; Thomas Percival, 'Medical Ethics: Or, A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons' (1803), in C. D. Leake, ed., *Percival's Medical Ethics* (Huntington, NY: Robert E. Krieger Publishing Company, 1975), 61-205. See also Gary S. Belkin, 'History and bioethics: The uses of Thomas Percival', *Medical Humanities Review*, 1998, 12, 39-59, who gives a variety of interpretations of Percival as learned gentleman, philosopher, and political actor.

⁴ Duncan Wilson, *The Making of British Bioethics* (Manchester: Manchester University Press, 2014), 29; Jukes Styrap, *A Code of Medical Ethics: With Remarks on the Duties of Practitioners to their Patients, and the Obligations of Patients to their Medical Advisers: also on the Duties of the Profession to the Public, and the Obligations of the Public to the Faculty* (London: J. & A. Churchill, 1878). See also Peter Bartrip, 'An Introduction to Jukes Styrap's *A Code of Medical Ethics* (1878)', in Robert Baker, ed., *The Codification of Medical Morality*, vol. 2: *Anglo-American*

found that doctors involved in the ethical work of the British Medical Association during the early twentieth century described professional interests and public interests as interlinked.⁵

Moreover, Roger Cooter has suggested that one should not adopt unreservedly Berlant's and Waddington's characterisations of the historical medical profession, because at the time of their writing, in the 1970s and early 1980s, the emergence of an apparently lay-driven bioethics would have stimulated them to focus on, and criticize, the self-interested features of the professional ethics of medical men.⁶ Historical accounts of the rise of bioethics during the second half of the twentieth century, especially by the field's pioneers, have indeed emphasized the role of non-medical protagonists, such as theologians, philosophers and lawyers, who were keen to put patient and public interests into the foreground of debates on ethics in medicine.⁷ Bioethicists who wished to demarcate the 'old' medical ethics from their 'new' interdisciplinary ethics may have unwittingly distorted historical perspectives by paying too little attention to the patient-related aspects of doctors' traditional ethics.⁸

Medical Ethics and Medical Jurisprudence in the Nineteenth Century (Dordrecht: Kluwer Academic Publishers, 1995), 145-148.

⁵ Andrew A. G. Morrice, "Honour and Interests": Medical Ethics and the British Medical Association', in Andreas-Holger Maehle and Johanna Geyer-Kordesch, eds, *Historical and Philosophical Perspectives on Biomedical Ethics: From Paternalism to Autonomy?* (Aldershot: Ashgate, 2002), 11-35, on 15.

⁶ Roger Cooter with Claudia Stein, *Writing History in the Age of Biomedicine* (New Haven and London: Yale University Press, 2013), 175.

⁷ Albert R. Jonsen, *The Birth of Bioethics* (New York and Oxford: Oxford University Press, 1998); Daniel Callahan, *In Search of the Good: A Life in Bioethics* (Cambridge, Mass. and London: MIT Press, 2012); David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (BasicBooks USA, 1991).

⁸ For a critical assessment of the rise of bioethics and the 'bioethicists' tale' see Roger Cooter, 'The Ethical Body', in idem and John Pickstone, eds, *Companion to Medicine in the Twentieth*

Going beyond these qualifications and criticisms of the traditional view of nineteenth-century medical ethics, I seek to further challenge it by looking into evidence for the contemporary *practice* of medical ethics (rather than just its normative texts) within a state-authorized system for the control of doctors' conduct in the United Kingdom. To what extent did nineteenth-century medical ethics, as a practice, support interests of patients and the public at large? What was the relationship between professional interests and patients' interests? My focus is the disciplinary function of the General Council of Medical Education and Registration (nowadays known as the General Medical Council or GMC), which was established through an Act of Parliament in 1858. As historian Michael Roberts has shown in his analysis of the genesis of this Act, three major factors contributed to this piece of medical reform: a drive towards professional representation from the rising group of general practitioners at a time when the old tripartite structure distinguishing physicians, surgeons and apothecaries was becoming dysfunctional; a public interest in ensuring competency and honourable behaviour of medical practitioners, a task which traditionally lay in the hands of the medical corporations (royal colleges); and the state's interest in qualified medical service in public health and under the terms of the Poor Law of 1834.⁹ Besides its role in monitoring standards of medical education, the General Council was given the task to maintain a Register of practitioners holding

Century (London and New York: Routledge, 2003), 451-468. See also Gary S. Belkin, 'Moving Beyond Bioethics: history and the search for medical humanism', *Perspectives in Biology and Medicine*, 47, 2004, 372-85.

⁹ Michael J. D. Roberts, 'The Politics of Professionalization: MPs, Medical Men, and the 1858 Medical Act', *Medical History*, 2009, 53, 37-56, on 39-43.

officially recognized medical qualifications. As a corollary to this latter function the Council was authorized to erase the names of those from the Register who had been wrongly placed on it; who had been convicted by a court of a misdemeanour (offence) or felony (crime); or who had been found guilty by the Council of 'infamous conduct in any professional respect'.¹⁰ Drawing upon the *Minutes of the General Council of Medical Education and Registration* for the years 1859-1914, I argue that the disciplinary cases can give us a clue to contemporary standards of medical professional ethics.¹¹ During this period the GMC dealt with over 400 such cases.¹² Legal and quantitative analysis of the GMC's cases from 1859 up to 1990 by Russell G. Smith has led to the criticism that the Council sometimes disciplined medical practitioners before giving them specific ethical guidance on the issue concerned.¹³ However, the disciplinary cases, when read in greater detail and in their specific contexts, do reveal the 'ethical compass' of the Council's physicians and surgeons who had been invested with the state's authority to decide on the professional fate of other medical practitioners. Referring to a variety of cases, ranging from fraudulent registration, sexual misconduct, and breach of confidence to alleged negligence in post-mortem examination, covering of unqualified assistants, and advertising, I

¹⁰ Walter Pyke-Lees, *Centenary of the General Medical Council 1858-1958: The History and Present Work of the Council* (London: William Clowes & Sons, [1958]), 1-4.

¹¹ *Minutes of the General Council of Medical Education and Registration of the United Kingdom* (London: W. J. & S. Golbourn, 1863ff). Hereafter cited as *Minutes*.

¹² Russell G. Smith, *Medical Discipline: The Professional Conduct Jurisdiction of the General Medical Council, 1858-1990* (Oxford: Clarendon Press, 1994), 238-55.

¹³ *Ibid.*, 57, 70; R. G. Smith, 'The Development of Ethical Guidance for Medical Practitioners by the General Medical Council', *Medical History*, 1993, 37, 56-67, 63; R. G. Smith, 'Legal Precedent and Medical Ethics: Some Problems Encountered by the General Medical Council in Relying upon Precedent when Declaring Acceptable Standards of Professional Conduct', in Robert Baker, ed., *The Codification of Medical Morality*, vol. 2: *Anglo-American Medical Ethics and Medical Jurisprudence in the Nineteenth Century* (Dordrecht: Kluwer Academic Publishers, 1995), 205-18, 212.

suggest that the medical men of the General Council tried to implement values that lay in patients' as well as doctors' interests.

The General Medical Council and Its Register

Before going into specific cases we need to clarify who the members of the GMC were who sat in judgement over their colleagues. Initially the Council comprised twenty-four members: nine represented the medical Royal Colleges of London, Edinburgh, Glasgow and Dublin, the Society of Apothecaries in London, and the Apothecaries' Hall in Dublin; seven represented the four English and three Irish universities and two the four Scottish universities; and six were nominated by the Queen on the advice of her Privy Council. All members were medically qualified men and can be seen as representing the professional establishment of the time.¹⁴ Only after a new Medical Act in 1886, five additional members were directly elected by the registered medical practitioners of the United Kingdom, a step which reflected the increased importance of general practice at that time.¹⁵ It also became then a requirement for registration that practitioners had certified proficiency in all the three main branches, 'medicine, surgery and midwifery', rather than just in medicine and/or surgery.¹⁶ In the period that I am looking at, 1858 to 1914, the General Medical Council had nine Presidents - eminent physicians or surgeons, from Sir Benjamin Brodie (term of office 1858-1860) to

¹⁴ Pyke-Lees, *Centenary*, 3; Anne Digby, *The Evolution of General Practice 1850-1948* (Oxford and New York: Oxford University Press, 1999), 39.

¹⁵ Donald MacAlister, 'The General Medical Council: Its Powers and Its Work', *British Medical Journal*, 1906, 2 (2388), 817-23, 820.

¹⁶ Roberts, 'Politics of Professionalization', 53.

Sir Donald MacAlister (term of office 1904-1931).¹⁷ By the early twentieth century, the Crown and the universities could appoint laymen to the Council, but did not choose to do so until 1926. From the 1880s, however, it became customary that the Council's solicitor and a barrister, as Legal Assessor, were present during disciplinary proceedings, and the accused medical practitioners also brought (or sent) their defence lawyers. The disciplinary proceedings thus adopted a format that was similar to court proceedings.¹⁸ Britain was not alone in institutionalising medical discipline in this quasi-legal manner; Prussia, for example, legally introduced so-called medical courts of honour for this purpose in 1899.¹⁹

The preamble of the 1858 Medical Act stated that its purpose was to enable 'persons requiring medical aid [...] to distinguish qualified from unqualified practitioners'.²⁰ That was in essence the function of the Medical Register, on which only those practitioners were admitted who held a recognized qualification from one of the above-mentioned licensing institutions represented on the Council, or who had been practising medicine in 1815. In 1859, almost 15,000 names were on this register, and the number increased to about 23,000 by 1880,

¹⁷ Pyke-Lees, *Centenary*, 30. Brodie had demonstrated his interest in medical professional ethics long before his appointment as President of the General Council, see Benjamin Brodie, 'Introductory Discourse on the Duties and Conduct of Medical Students and Practitioners. Addressed to the Students of St. George's Hospital, October 2, 1843', in *The Works of Sir Benjamin Collins Brodie*, collected and arranged by Charles Hawkins, 3 vols (London: Longman, Green etc., 1865), I, 485-505

¹⁸ MacAlister, 'General Medical Council', 820; Smith, 'Legal Precedent', 207.

¹⁹ See Andreas-Holger Maehle, *Doctors, Honour and the Law: Medical Ethics in Imperial Germany* (Basingstoke: Palgrave Macmillan, 2009), 6-46.

²⁰ Cited in MacAlister, 'General Medical Council', 817.

and c. 50,000 by 1924.²¹ Being unregistered, however, did *not* prevent someone from practising medicine. Registration was only required for fulfilling official functions, such as issuing a death certificate, or for holding positions in public employment, e.g. serving as a medical officer or practising under the 1911 National Health Insurance scheme. Also, only registered practitioners were entitled to sue in the courts for their fees.²² Nevertheless, the prestige and professional legitimacy that registration brought are not only reflected in the rising numbers of registered practitioners but also in disciplinary cases in which practitioners erased from the Register keenly sought to have their names restored. For example, Leeds doctor Henry Arthur Allbutt, who had been struck off in 1887 for publishing a booklet including contraceptive advice which was considered detrimental to 'public morals', took the General Council to court to have his name placed back on the Register and seeking damages for libel.²³ Other practitioners wrote to the Council with long apologies or detailed

²¹ Pyke-Lees, *Centenary*, 3. According to Digby an important reason for the increase in the numbers of registered practitioners was the growing number of graduate entrants in the Register; by 1913 the total number of practitioners on the Register had reached about 42,000. Cf. Digby, *Making a Medical Living*, 15-16.

²² MacAlister, 'General Medical Council', 817; Margaret Stacey, *Regulating British Medicine: The General Medical Council* (Chichester: John Wiley & Sons, 1992), 18-19; Roberts, 'Politics of Professionalization', 47.

²³ *Minutes*, vol. 24, 1887, 122-23, 307-13, 316-17; vol. 26, 1889, 181-83. The publication concerned was Arthur H. Albutt, *The Wife's Handbook: How a woman should order herself during Pregnancy, in the Lying-in Room, and after Delivery*, 2nd edn (London: W. J. Ramsey, 1886). Chapter VII (46-50) gave details of various contraceptive techniques and devices, including the names of the firms from where to obtain the latter. Advertisements for the devices, such as 'The Improved Check Pessary' and 'Malthusian Appliance – The Improved Vertical and Reverse Syringe', appeared at the end of the booklet. For further details and the neo-Malthusian context of the Allbutt case see Angus McLaren, *Birth Control in Nineteenth-Century England* (New York: Holmes & Meier Publishers, 1978), 112, 132-33.

justifications of the conduct that had led to erasure of their names, hoping to have them restored.²⁴

Examples of Disciplinary Cases and Their Interpretation

It is therefore unsurprising that a series of early disciplinary cases were concerned with fraudulent registration, i.e. with practitioners who falsely declared to have a registrable qualification or tried to obtain one by fraud. If the Council found practitioners guilty of such an offence, they were erased from the Register.²⁵ While these decisions were recorded without much comment one can safely assume that the Council aimed to fulfil here its task of enabling the public to identify qualified practitioners. One might, of course, also take the more sceptical line of interpreting those erasures as a process of professional boundary demarcation from the 'unqualified', carried out in the economic interest of the 'qualified' practitioners. The issue of fraud in medical titles was as such not new: already in the early 1850s there had been complaints about this matter in connection with the publication of the (unofficial) *British Medical Directory*.²⁶

It would be rash, however, to view the early disciplinary cases simply as expressions of professional self-interest. In 1873, for example, the Council erased a medical doctor from the Register because of sexual relations with a

²⁴ See e.g. *Minutes*, vol. 19, 1882, 83-85 (following erasure in 1877 because of criminal conviction for attempted sodomy); vol. 33, 1896, 232-37 (following erasure in 1894 for advertising for a company). On the latter case (Herbert Tibbits), see below.

²⁵ See e.g. *Minutes*, vol. 1, 1863, 94-97, 103-104, 213, 245, 251; vol. 2, 1864, 341-42

²⁶ 'Fictitious Medical Titles', *The Lancet*, 21 August 1852, 179.

female patient. The initial complaint, that he had ‘seduced and carnally known’ her, had been made by the patient’s uncle, a solicitor.²⁷ The doctor’s petition, two years later, to have his name restored to the Register was rejected, as was his further request to this effect in the following year.²⁸ Only at the third attempt, after a total of eleven years, was his name restored.²⁹ This was a typical case of ‘infamous conduct in a professional respect’ that constituted a violation of moral standards of the medical profession in relation to patients. The rule against sexual relations with patients had already been part of the Hippocratic Oath.³⁰ It was also behind the vow to practise ‘chastely’ in Edinburgh University’s Medical Oath, which had been sworn since the early 1730s.³¹ In the moralistic climate of the nineteenth century the rule aimed both at protecting patients and at preventing reputational damage to the profession.³² Seen in this light it is understandable that the GMC in this disciplinary case repeatedly rejected the doctor’s application to restore his name to the Register – taking a firm line in a matter like this protected the GMC’s own reputation.

Another early GMC case concerned medical confidentiality – a rule likewise mentioned in the Hippocratic Oath, but also in nineteenth-century British works on medical deontology, such as Percival’s *Medical Ethics* and Michael Ryan’s *A*

²⁷ *Minutes*, vol. 10, 1872-73, 149-50.

²⁸ *Minutes*, vol. 12, 1875, 23; vol. 13, 1876, 333.

²⁹ Smith, *Medical Discipline*, 240.

³⁰ ‘Into as many houses as I may enter, I will go for the benefit of the ill, while being far from all voluntary and destructive injustice, especially from sexual acts, both upon women’s bodies and upon men’s, both of the free and of the slaves.’ See Steven H. Miles, *The Hippocratic Oath and the Ethics of Medicine* (New York: Oxford University Press, 2004), xiv, 139-48.

³¹ Robert Baker, *Before Bioethics: A History of American Medical Ethics from the Colonial Period to the Bioethics Revolution* (New York: Oxford University Press, 2013), 37, 49.

³² See also Digby, *Evolution of British General Practice*, 282.

Manual of Medical Jurisprudence.³³ This case concerned a medical doctor, John Pattison, who had qualified in New York but was practising in London. In 1868, he had accused the husband of a patient with breast cancer of ‘stubbornness’, because he had refused to follow the doctor’s advice to take her after local treatment of the tumour for recuperation to the south of France over the winter months. Instead the husband eventually took her at the end of January to the seaside at Hastings, where she died a few days later. The doctor was further aggrieved by the fact that the husband refused to pay the full bill for numerous home visits to the sick wife, and he warned the husband in writing that he was going to publish the circumstances and details of the case in a medical book.³⁴ When the husband returned the doctor’s letters, which included accusations of ‘shabby conduct’, to the dead-letter office, Pattison sent them by open post, so that they could be read by anyone, and threatened that he would next time write them on cardboard and send them to the husband’s club. The husband, Charles Hay Frewen, a Royal sheriff and former Member of Parliament, took the doctor to court for libel and breach of the peace.³⁵ At the second court hearing Pattison apologized through his lawyer to Frewen and assured to have published his book without including the case history concerned. Frewen’s lawyer then withdrew the

³³ ‘And about whatever I may see or hear in treatment, or even without treatment, in the life of human beings – things that should not ever be blurted out outside – I will remain silent, holding such things to be unutterable.’ See Miles, *Hippocratic Oath*, xiv, 149-57. Percival, ‘Medical Ethics’, 90; Michael Ryan, ‘A Manual of Medical Jurisprudence and State Medicine’ (1836), in H. Brody, Z. Meghani and K. Greenwald, eds, *Michael Ryan’s Writings on Medical Ethics* (Dordrecht: Springer, 2010), 79-222, 157-58.

³⁴ *Minutes*, vol. 7, 1869, 41-45.

³⁵ ‘Court of Queen’s Bench, Westminster, Jan. 25’, *The Times*, issue 26344, 26 January 1869, 11.

charges, so that the court, somewhat reluctantly, dismissed the case.³⁶ However, the General Medical Council, on learning about this court case from newspaper reports, decided to hold its own inquiry into the matter, found Pattison guilty of infamous conduct in a professional respect and erased his name in 1869 from the Register. His petition in 1871 to have his name restored was rejected by the Council.³⁷ The sparse GMC *Minutes* unfortunately give us no information about the Council's reasoning behind their decisions. However, it is clear that the deontological literature, in particular Percival and Ryan, had described unauthorized disclosures as unethical. As Ryan had put it in 1836:

The confidence reposed in him [i.e. the medical practitioner], and revelations made to him, during his professional attendance, are such that honour commands him not to abuse the one, or publish the other, unless in our courts of justice, which have the power to compel him. [...] such secrets are not to be divulged without the greatest necessity [...].³⁸

Russell Smith has identified Pattison's case as the GMC's first disciplinary case on medical confidentiality, and deplores that the GMC began to publish guidance on this topic only over a hundred years later.³⁹ However, it is quite clear from the context of the case that the Council acted on a contemporary, professional as well as public expectation about the requirements of discreet behaviour in a

³⁶ 'Court of Queen's Bench, Westminster, Feb. 1', *The Times*, issue 26350, 2 February 1869, 8-9.

³⁷ *Minutes*, vol. 7, 1869, 41-45, 159, 162; vol. 9, 1871, 14.

³⁸ Ryan, 'Manual', 157.

³⁹ Smith, 'Legal Precedent', 211. Actually, GMC Legal Assessor Muir Mackenzie prepared a memorandum on the obligations of medical practitioners regarding professional secrecy in 1899 which was published in the *British Medical Journal* and *The Lancet*. Cf. Angus H. Ferguson, *Should a Doctor Tell? The Evolution of Medical Confidentiality in Britain* (Farnham: Ashgate, 2013), 28, 37-38; Andreas-Holger Maehle, *Contesting Medical Confidentiality: Origins of the Debate in the United States, Britain, and Germany* (Chicago: The University of Chicago Press, 2016), 30.

doctor and enforced this social expectation through its decisions. In 1851, the Scottish Court of Sessions case of A.B. v. C.D., in which a doctor was accused of having disclosed sensitive family information of the plaintiff to the minister of his parish, had established that the relationship between medical adviser and the person consulting him implied an obligation of secrecy that, if violated, could give proper grounds for legal action. Only in a court of law doctors were expected, and compelled, to testify concerning patient details.⁴⁰ In Pattison's case, then, the GMC acted on the supposed interests of the patient respectively their family in medical secrecy. These interests were apparently not in conflict with professional interests which were concerned about the public reputation of medical practitioners.

Another case indicated, however, the limits of the GMC's disciplinary role. In April 1881, the King and Queen's College of Physicians in Ireland sent a complaint about Richard Albert Shipman Prosser, a Member of the Royal College of Surgeons of England and Licentiate of the Society of Apothecaries in London, to the General Medical Council. Prosser had sworn in a coroner's court that he had performed a post-mortem examination on a female patient's body, in which he examined the kidneys and all other abdominal viscera, finding the kidneys healthy. On the basis of this examination, he had accused the medical practitioner who had treated the patient of having caused her death by negligence. On this evidence the practitioner concerned, Edward Hyacinth

⁴⁰ Walter F. Pratt, *Privacy in Britain* (Lewisburg: Bucknell University Press, and London: Associated University Presses, 1979), 46-47; Ferguson, *Should a Doctor Tell?*, 24-26; and Maehle, *Contesting Medical Confidentiality*, 9-10.

O'Leary, a Licentiate of the King and Queen's College of Physicians, had been charged with manslaughter and imprisoned. A second-post mortem examination by two other medical practitioners then showed, however, that the kidneys had not been removed from their place during the autopsy and that also the other abdominal organs appeared to have been incompletely examined. Following this information the manslaughter charge against O'Leary was dropped, and he was released from prison. King and Queen's College held that Prosser's behaviour amounted to infamous conduct in a professional respect and asked the GMC to erase his name from the Register.⁴¹ So in this case, Prosser, who had made the accusation of negligence about a fellow-practitioner, was himself suspected of having been negligent, namely in his post-mortem examination, with the serious consequence that the practitioner accused by him had been indicted with manslaughter and arrested.⁴²

The initial response of the GMC Branch Council for England, which first looked at the complaint, was that this case did not seem to be one in which the Council could 'usefully take action'. King and Queen's College, dissatisfied with this reply, repeated its complaint in May 1881. The Branch Council was still unwilling to take the matter further, seeing it as a case of 'conflicting evidence' and noting that no legal action had been taken against Prosser for perjury. However, the central General Medical Council decided that the Branch Council should inquire

⁴¹ *Minutes*, vol. 18, 1881, 266-67.

⁴² On nineteenth-century notions of negligence see Kim Price, *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law, c. 1834-1900* (London: Bloomsbury Academic, 2015).

further into Prosser's conduct in this case.⁴³ Having obtained and considered their solicitor's report on the case and having consulted with the General Council's solicitor, the Branch Council concluded eventually, in March 1883, nearly two years after the initial complaint, that there were no grounds for finding Prosser guilty of infamous conduct in a professional respect.⁴⁴ In spite of the intervention of two GMC members, who wanted to see the report of the second post-mortem examination, the General Medical Council agreed with this conclusion the following month.⁴⁵

Apart from throwing a light on the power relations between a royal college, the General Medical Council and one of its branch councils, the Prosser case illustrates the difficulties the GMC had early on in forming an opinion on the quality of medical performance. The reference to 'conflicting evidence' is quite revealing in this regard. In the end, the GMC followed the legal assessments of its solicitors, which in turn were informed by the decisions of the general courts involved. It summoned neither Prosser nor O'Leary to hear them directly about their sides of the case, whereas it had summoned the accused practitioners in the sexual misconduct and breach of confidentiality cases mentioned above. So how did the early GMC then address its task of protecting the public against poorly *performing* medical practitioners, as distinct from practitioners whose *moral* conduct was questionable?

⁴³ *Minutes*, vol. 18, 1881, 213-14, 267; vol. 19, 1882, 100, 197-99, 212.

⁴⁴ *Minutes*, vol. 20, 1883, 222-23.

⁴⁵ *Minutes*, vol. 20, 1883, 32-33.

Two Major Issues: Covering Unqualified Assistants and Medical Advertising

As the mentioned cases on fraudulent registration indicated, the GMC's approach focused on medical qualifications, and in fact the related matter of covering unqualified assistants became a key issue in the late nineteenth century. The problem was, in short, that some qualified medical men, who ran large practices, employed unqualified assistants (that is, assistants without a registrable qualification), allowing them to do unsupervised work which was supposed only to be carried out by a qualified medical practitioner. Such assistants sometimes gave the wrong impression to patients that they were regular doctors.⁴⁶ A GMC Committee looking into substantial evidence on this issue concluded in 1883 that the system of employing unqualified assistants was widespread in England and Wales, especially in general practice for the large mining and manufacturing populations. The Committee expressed concern that this system was blocking employment opportunities and earnings for qualified assistants. But above all it saw the system as 'fraud on the public', comparable to the public offence of lawyers who covered persons falsely pretending to be a solicitor or attorney, which was punishable with withdrawal of the lawyer's practising license and a prison sentence for the unqualified person. The qualified medical practitioners who covered an unqualified assistant, for example by signing medical or death certificates on patients they had not seen themselves, were held to be guilty of 'infamous conduct'. Their behaviour frustrated the fundamental principle of the 1858 Medical Act that it should enable the public to

⁴⁶ *Minutes*, vol. 21, 1884, 252; vol. 23, 1886, 117.

distinguish between qualified and unqualified practitioners.⁴⁷ So, in this matter the GMC aimed to protect the public against incompetent treatment, though not by control of performance but indirectly by control of medical employment. It acted here in the interest of the public, while simultaneously supporting the employment opportunities for junior, qualified practitioners.

The Committee's recommendation to discipline practitioners who covered unqualified assistants was adopted by the GMC, which decided to publish a warning on this issue in the same year, 1883.⁴⁸ This was the first of the GMC's official Warning Notices, which specified types of behaviour that might lead to a disciplinary inquiry and erasure from the Register.⁴⁹ Numerous charges of covering unqualified assistants were heard by the GMC until this type of disciplinary offence became less frequent in the years after 1900.⁵⁰ A particularly prominent case of this kind was that of Dr Walter Day and Mr William Davenport in 1886. It had been reported by the Deputy Coroner for Westminster, Athelstan Braxton Hicks, to the Secretary of State for the Home Department, before the latter forwarded the material to the GMC, asking the Council to deal with it, 'as the practice of employing unqualified practitioners as assistants by medical men is very common, especially by medical men presiding over dispensaries.'⁵¹ A coroner's inquest had been held over the body of a 53-year-old labourer, as Dr

⁴⁷ *Minutes*, vol. 20, 1883, 39-45, 51-85.

⁴⁸ *Minutes*, vol. 20, 1883, 91.

⁴⁹ By 1914 Warning Notices had also been issued regarding issues with certification, sale of poisons, dangerous drugs, association with unqualified practitioners, and advertising and canvassing. Smith, 'Development of Ethical Guidance', 61.

⁵⁰ Smith, *Medical Discipline*, 103, 241-55.

⁵¹ *Minutes*, vol. 23, 1886, 114.

John Pugh, who had been called by the family for emergency help in the night the man was dying, suspected that the patient had only been treated in his last illness by an unqualified practitioner, Davenport, who worked as an assistant in Dr Day's dispensary. Pugh had therefore refused to give a death certificate and written to the Registrar of Deaths. Dr Day had subsequently signed the death certificate wrongly entering as the last date he had seen the patient the day on which Davenport had actually attended him. However, Day claimed to have personally seen to the patient in the dispensary two days earlier when the latter had presented with symptoms of acute bronchitis. While the post-mortem examination did not reveal anything suspicious, indicating heart failure upon congestion of the lungs, and Davenport's treatment appeared to have been appropriate, the coroner was alarmed about the circumstances of the death certificate, in particular as Davenport had a previous conviction for perjury. Concerned about 'the poor' being treated by unqualified men who were unable to give valid certificates for their insurance clubs, Braxton Hicks had informed the Home Secretary. The latter had subsequently consulted the Registrar-General, who advised against taking legal action against Dr Day, given that he had declared under oath to have personally seen the patient only two days before the patient's death.⁵² Braxton Hick's involvement as coroner and the holding of an inquest over the patient's body was in line with a general, though not uncontroversial policy at this time: that all deaths not certified by a registered medical practitioner should be referred to the coroner, who would then decide

⁵² *Minutes*, vol. 23, 1886, 114-21.

whether an inquest should be held.⁵³ As Ian Burney has argued, the threat to a deceased person's family of the unwanted publicity of a coroner's inquest can be seen as an instrument of the medical profession to discipline the population into seeking qualified medical care and avoiding unlicensed practitioners.⁵⁴ While this interpretation points to professional self-interest in cases such as this, there appears to have also been genuine concern about the quality of care provided by unqualified assistants such as Davenport. The General Medical Council, upon advice of its solicitor, decided to take no action against Dr Day, but took the opportunity to inform the Home Department and the Privy Council about the recent GMC inquiry into the issue of employing unqualified assistants, including the subsequent Warning Notice of 1883 and a resolution then taken to ask for legislation on the matter.⁵⁵ It also defined more clearly the circumstances under which a registered practitioner might be 'censured' for covering an unqualified assistant. This was held to be likely if the unqualified assistant practised 'in complete substitution' for the registered practitioner's services or under circumstances where 'due personal supervision and control' by the latter were not, or could not be, exercised.⁵⁶

The implications of this position of the GMC are illustrated by another disciplinary case on covering an unqualified assistant, in 1910. Being the first case in which

⁵³ Ian A. Burney, *Bodies of Evidence: Medicine and the Politics of the English Inquest 1830-1926* (Baltimore and London: Johns Hopkins University Press, 2000), 75-76.

⁵⁴ *Ibid.*, 77.

⁵⁵ *Minutes*, vol. 23, 1886, 256; vol. 24, 1887, 143-44, 357.

⁵⁶ *Minutes*, vol. 25, 1888, 36-37.

the British Medical Association acted as official complainant to the GMC, it received detailed coverage in the *British Medical Journal*.⁵⁷ As the BMA's Medical Secretary, James Smith Whitaker, asserted in the relevant GMC hearing, 'the case was of considerable public importance'.⁵⁸ David Thomas Jones, a qualified surgeon running a large practice with three partners in Sheffield, stood accused of having allowed his medically unqualified dispenser and surgery attendant, William Perry, to attend one of his working-class patients, Mrs Alice Hannah Nicholson, when she gave birth to twins. Initially, Perry had rushed to see to Mrs Nicholson in an emergency situation, as she had started to give birth and neither Jones nor the other doctors of the practice had been available at the time. However, Jones being busy the following days as well, allowed his assistant to visit her two more times after the birth, which appeared to have been uncomplicated, and also to take care of the official notification of birth form, in which Perry inserted Jones's name as the doctor attending. When Jones eventually followed a call to personally visit Mrs Nicholson four days after the birth, she had developed puerperal fever. Though transferred immediately to a local workhouse infirmary, where retained pieces of placenta were removed, she died there a few days later. On learning about the case, Sheffield's Medical Officer of Health contacted the coroner, who – following also a personal request of the widower, Mr Nicholson – arranged for an exhumation of the already buried

⁵⁷ 'Disciplinary Cases before the Medical Council', *British Medical Journal*, 4 June 1910, 1366-67; General Council of Medical Education and Registration, 'Medical Disciplinary Cases. The Case of Mr. David Thomas Jones', *Supplement to the British Medical Journal*, 4 June 1910, 340-47. The BMA had a Central Ethical Committee since 1902. See Morrice, 'Medical Ethics and the British Medical Association'.

⁵⁸ General Council, 'Medical Disciplinary Cases', 340.

body. The post-mortem examination indicated that Mrs Nicholson had died from 'purely natural causes', which 'would include puerperal septicaemia [blood poisoning]',⁵⁹ and that there were no injuries caused by the delivery. Still, the Medical Officer of Health ensured that the case went, via the British Medical Association as complainant, to the GMC.⁶⁰ After hearing Jones and witnesses, and considering depositions from individuals involved in the case, the GMC found Jones guilty of infamous conduct in a professional respect and erased his name from the Register.⁶¹ His name was restored 30 months later.⁶²

The Day-Davenport case and the Jones-Perry case thus illustrate how the issue of employing unqualified assistants was bound up with suspicions of incompetent practice - even though in the former case family members of the deceased declared during the inquest that they had always been satisfied with 'Dr Davenport', and in the latter case, Jones provided evidence that members of Mrs Nicholson's family had continued to see him as their doctor after her death.⁶³ Employing and covering unqualified assistants was seen as a professional offence not only because it precluded employment opportunities for qualified junior practitioners but also because it could involve serious danger for patients. By the mid-1920s the position of the GMC on the issue was unmistakably clear. As barristers William Sanderson and E. B. A. Rayner warned in their textbook on legal aspects of medical practice:

⁵⁹ *Ibid.*, 342.

⁶⁰ *Ibid.*, 340-47.

⁶¹ *Ibid.*, 347; *Minutes*, vol. 47, 1910, 46-48.

⁶² Smith, *Medical Discipline*, 253.

⁶³ *Minutes*, vol. 23, 1886, 117; General Council, 'Medical Disciplinary Cases', 344.

The General Medical Council regards the employment of an unqualified person as an assistant, as fraudulent and dangerous to the public interest, and will take every step in its power to prevent or punish practitioners who act in contravention of this rule. The Council is equally determined to suppress the practice of “covering,” by which expression is meant countenancing or assisting an unqualified or unregistered person to attend or treat patients.⁶⁴

When, in 1906, GMC President Donald MacAlister commented on the influence of the Council on the development of medical professional ethics, he cited the issue of covering unqualified assistants as an example of effective intervention.⁶⁵ His other example was the issue of medical advertising, on which the GMC had expressed its disapproval in a resolution in 1899.⁶⁶ In late nineteenth-century Britain medical advertising in newspapers and other forms of attracting patients, such as distribution of handbills or canvassing through health insurance societies, had become increasingly prevalent, linked to relative overcrowding of the profession and competition between practitioners. The medical establishment of the GMC, however, saw advertising as potentially ‘infamous conduct’: not only was it perceived as unfair competition, but coming from the world of trade, standing in the tradition of quackery, and often being linked with unorthodox

⁶⁴ William Sanderson and E. B. A. Rayner, *An Introduction to the Law and Tradition of Medical Practice* (London: H. K. Lewis & Co., 1926), 29.

⁶⁵ MacAlister, ‘General Medical Council’, 819.

⁶⁶ Robert Saundby, *Medical Ethics: A Guide to Professional Conduct*, 2nd edn (London: Charles Griffin & Company, 1907), 128.

treatments, it was regarded as profoundly ungentlemanly and as endangering the profession's reputation.⁶⁷

The issue had been long-standing. Since the late 1850s the *Lancet* had regularly published complaints of medical practitioners about colleagues' 'unprofessional' circulars or frequently repeated newspaper advertisements for their services or book publications, and it had commented that such tradesman-like conduct was lowering the profession's standing in the eyes of the public.⁶⁸ In 1871 a *Lancet* editorial complained that the medical corporations, in particular the Royal College of Surgeons of England and the Royal College of Physicians of London, did too little to discipline such behaviour of their fellows, members and licentiates, although they had appropriate powers and structures to do so.⁶⁹ By 1873 the Royal College of Surgeons had adopted a resolution condemning frequent advertising of medical works in the non-medical press, and the Royal College of Physicians had endorsed this resolution.⁷⁰ Also, the various forms of advertising were unmistakably censured in the medical deontological literature. As Jukes Styrap pointed out in his *A Code of Medical Ethics*:

⁶⁷ Morrice, "Honour and Interests", 24-26; Jochen Binder, *Zwischen Standesrecht und Marktwirtschaft: Ärztliche Werbung zu Beginn des 20. Jahrhunderts im deutsch-englischen Vergleich* (Frankfurt/M.: Peter Lang, 2000), 75-83.

⁶⁸ 'Unprofessional Advertising', *The Lancet*, 22 January 1859, 101; 'Unprofessional Handbills', *ibid.*, 3 December 1859, 578; 'Unprofessional Advertisements', *ibid.*, 9 November 1861, 464; 'Professional Advertising', *ibid.*, 6 June 1868, 731; 'Professional Advertising', *ibid.*, 6 February 1869, 215; 'Professional Advertising', *ibid.*, 20 March 1869, 407-408; 'Unprofessional Advertising', *ibid.*, 29 May 1869, 758; 'Unprofessional Advertising', *ibid.*, 5 June 1869, 799; 'Unprofessional Advertising', *ibid.*, 19 June 1869, 854.

⁶⁹ 'The Ethical Function of the Corporations', *The Lancet*, 25 November 1871, 753-54.

⁷⁰ 'Professional Book Advertisements', *The Lancet*, 21 December 1872, 893; 'Medical Advertisements', *ibid.*, 17 May 1873, 711-12; 'Medical Advertising', *ibid.*, 28 June 1873, 913.

It is [...] derogatory to the profession to solicit practice by advertisement, circular, card, or placard; also, to offer, by public announcement, gratuitous advice to the poor, or to promise radical cures; to publish cases and operations in the daily press, or knowingly, to suffer such publications to be made; to advertise medical works in non-medical papers; to invite laymen to be present at operations; to boast of cures and remedies; to adduce testimonials of skill and success; or to do any like acts. Such are the ordinary practices of charlatans, and are incompatible with the honour and dignity of the profession. [...] It is also extremely reprehensible for a practitioner to attest the efficacy of patent or *secret medicines*, or, in any way, to promote their use; only less culpable is the practice of written testimony in favour of articles of commerce, and tacitly or otherwise sanction its publication.⁷¹

However, the issue of medical advertising continued to cause concern. In 1879 the *Lancet* noted that scarcely a week passed ‘without receiving communications from medical men who are annoyed by the paltry and unprofessional devices to which some of their neighbours resort to obtain public notice and “patronage”’.⁷² Unwilling to keep on publishing about individual cases of this kind, the journal resigned itself to the hope that the public would ‘in the long run discover that the persons and the commodity that need so much advertising cannot be of great value or repute.’⁷³

The *Medical Press and Circular*, however, took on the cause, pointing out in 1882 that a recent resolution by the Royal College of Physicians against advertising medical works in the lay press would remain entirely ineffective as long as the only consequence for perpetrators was loss of professional esteem. Only if the punishment consisted in loss of license, membership or fellowship of

⁷¹ Styrap, *Code of Medical Ethics*, 27-28.

⁷² ‘Medical Advertising’, *The Lancet*, 27 September 1879, 485.

⁷³ *Ibid.*

the College, a measure that would then also be adopted by the other medical corporations, medical advertising would be stamped out.⁷⁴ Similarly, when the King and Queen's College of Physicians in Ireland passed later in the same year a resolution that described extensive advertising of medical works and giving 'laudatory certificates' of medicinal preparations and medical or surgical appliances as 'misleading to the public, derogatory to the dignity of the profession', and contrary to the College's traditions, the *Medical Press* criticized it as too vague and as 'impotent'.⁷⁵

Yet, despite such worries, disciplinary action was taken in several cases. In 1887, for example, the Royal College of Surgeons in Ireland and the King and Queen's College of Physicians reported to the General Medical Council that they had withdrawn their diplomas from a practitioner, William Edward Robson, 'for having wilfully violated their regulations by publishing advertisements derogatory to the reputation, honour and dignity of the College'.⁷⁶ His name was erased from the GMC's Register but restored after 33 months.⁷⁷ A leading article in the *Medical Press* in the same year, 1887, pointed out that problematic self-advertisement occurred among professionally established practitioners as well as 'the young and struggling', and was 'derogatory' anywhere, but 'doubly so when the daily bread is no longer at stake'.⁷⁸ In fact, in the following year a correspondent to the *Medical Press* accused even a member of the General

⁷⁴ 'Advertisement as a Crime', *The Medical Press and Circular*, 14 June 1882, 509-11.

⁷⁵ 'Medical Advertising', *The Medical Press and Circular*, 8 November 1882, 401.

⁷⁶ 'The Penalty of Advertising', *The Medical Press and Circular*, 23 February 1887, 183.

⁷⁷ Smith, *Medical Discipline*, 243.

⁷⁸ 'Professional Advertising', *The Medical Press and Circular*, 16 March 1887, 246-47.

Medical Council itself, the ophthalmic surgeon Robert Brudenell Carter, FRCS, of publishing a ‘glaring puff’ for his dexterity and skill in the *Times* and the *Pall Mall Gazette*.⁷⁹ Prominent in the GMC *Minutes* of the 1890s was the case of Dr Herbert Tibbits, a proponent and practitioner of the then controversial method of electrotherapy with weak currents.⁸⁰ The Royal College of Physicians of London had withdrawn his licentiateship and the Royal College of Physicians of Edinburgh his membership and fellowship, as he was deemed to have issued a ‘laudatory certificate’ on appliances of the Medical Battery Company. Tibbits protested against their decision in a letter to the GMC, pointing out that he had merely made a pre-paid ‘Report’ to the Company after testing some of their appliances, but had not published the report himself.⁸¹ Nevertheless, the GMC decided to hold an inquiry into his conduct and in December 1894 found him guilty of ‘offences [...] infamous in a professional respect’ and erased his name from the Register. His efforts in the following two years to have his name restored were unsuccessful.⁸² In Tibbits’ case it seems, the combination of product advertising (‘laudatory certificate’), a link to a manufacturing company, and his support for an unorthodox or at least rather marginal form of treatment,

⁷⁹ M.R.C.S., ‘The *Times* as a Medium of Medical Advertisement’, *The Medical Press and Circular*, 5 September 1888, 246. The issue of so-called indirect advertising by medical men who published on medical and health matters in the general press continued to exercise the GMC and the British Medical Association during the 1920s. See Andrew A. G. Morrice, “The Medical Pundits”: Doctors and Indirect Advertising in the Lay Press 1922-1927’, *Medical History*, 1994, 38, 255-80.

⁸⁰ On ‘medical electricians’ in the Victorian period, including Tibbits, and electrotherapy’s ‘vexed status’ between regular and irregular practice see Iwan Rhys Morus, ‘Bodily Disciplines and Disciplined Bodies: Instruments, Skills and Victorian Electrotherapeutics’, *Social History of Medicine*, 2006, 19, 241-59.

⁸¹ *Minutes*, vol. 31, 1894, 70-74.

⁸² *Minutes*, vol. 31, 1894, 74, 153-54, 156-57; vol. 33, 1896, 232-37.

went firmly against him.⁸³ It should be noted though that the 1858 Medical Act did not permit to erase a practitioner's name from the Register 'on the grounds of his having adopted any Theory of Medicine or Surgery'.⁸⁴

Eventually, in 1905, a formal GMC Notice on advertising and canvassing described these methods as 'contrary to the public interest and discreditable to the profession of medicine' and warned that any practitioner resorting to such practices rendered himself liable to the charge of 'infamous conduct in a professional respect' and might have his name erased from the Register if found guilty.⁸⁵ As GMC member and Vice-President of the British Medical Association, Robert Saundby, explained in his booklet *Medical Ethics: A Guide to Professional Conduct* in 1907:

No medical practitioner should seek publicity by advertisement except in certain recognized ways, as to do so is to attempt to get practice by other than the legitimate means of proficiency in his profession and skill or success in dealing with his patients. The only advertisement to the public now permissible is the door-plate [...].⁸⁶

Between 1900 and 1914 advertising and canvassing belonged to the most common disciplinary offences. From a total of 206 disciplinary cases dealt with

⁸³ Advertising, in particular self-advertisement, had also provided the grounds for the erasure from the Register of naturopath and anti-vaccinationist doctor Thomas Richard Allinson in 1892; see *Minutes*, vol. 26, 1889, 211-18; vol. 29, 1892, 75, 79-81, 154. For a full discussion of Allinson's case, see P. S. Brown, 'Medically Qualified Naturopaths and the General Medical Council', *Medical History*, 1991, 35, 50-77.

⁸⁴ Cited *ibid.*, 54.

⁸⁵ *Minutes*, vol. 42, 1905, 249-50; Saundby, *Medical Ethics*, 129. See also MacAlister, 'General Medical Council', 819.

⁸⁶ Saundby, *Medical Ethics*, 3.

by the GMC during this period, 23 concerned advertising and 18 canvassing.⁸⁷ Again, as in the matter of covering unqualified assistants (which still concerned 26 cases in the same period), the Council's disciplinary stance derived not only from professional self-interest (i.e. the intention to mitigate competition) but also from a claim to protect the public against unscrupulous practice. As Saundby maintained, the lay public was unable to judge, for example, the value of advertised patent medicines, and he warned:

If medical practitioners advertised [...] [t]here would be in consequence a general lowering of the standard of the profession, its ranks would be crowded with sharp business men, and the true scientific worker would be elbowed out and starved, until the public found out, as it might do after long years, that a bold liar is not a trustworthy medical adviser [...].⁸⁸

Conclusions

From the variety of cases discussed in this paper it is clear that in the nineteenth and early twentieth centuries the GMC was concerned about two broad matters: the moral conduct of practitioners and the safeguarding of qualified practice.

Disciplinary actions in these areas were taken in the interest of patients and the public, based on the legal remit that was given to the Council in the Medical Act of 1858. Some of the measures taken, in particular against unqualified practice and against medical advertising, also favoured interests of qualified, orthodox and established practitioners, as one would expect from a body that was composed of this type of practitioners. A shortcoming of the GMC was that it had

⁸⁷ Smith, *Medical Discipline*, 248-55.

⁸⁸ Saundby, *Medical Ethics*, 5-6.

no direct control over medical performance, only indirectly through the monitoring of educational standards and practitioners' qualifications. To its credit, the GMC attempted through its disciplinary role to ensure that the public could receive treatment from trustworthy and competent medical practitioners. However, this system of professional self-regulation and discipline had serious weaknesses, as became obvious in the second half of the twentieth century, especially in the 1990s with the Bristol paediatric heart surgery scandal and with the case of medical serial killer Harold Shipman.⁸⁹ Since then, the GMC, for a time fearing for its continued existence, has made considerable efforts to ensure safe medical practice for the public, for example by creation of a Medical Practitioners Tribunal Service, which is still part of the GMC but answerable to Parliament, and by introducing a revalidation of practitioners scheme.⁹⁰ The long-term effects of these changes, which were implemented from 2012, remain to be seen. However, from a historical perspective, it would be unfair to doubt the GMC's foundational intention to serve the interests of patients and the public at large as well as to protect the interests of qualified medical practitioners. The practice of medical ethics in the nineteenth century, as reflected in the disciplinary activities of the GMC, was more patient-oriented than has been generally assumed in the age of bioethics. In that sense, the history of medicine suggests that modern bioethics was less of an innovation than has been claimed.

⁸⁹ Margaret Stacey, *Regulating British Medicine: The General Medical Council* (Chichester: John Wiley & Sons, 1992); M. Stacey, 'The General Medical Council and Professional Self-Regulation', in David Gladstone, ed., *Regulating Doctors* (London: Institute for the Study of Civil Society, 2000), 28-39; Donald Irvine, *The Doctors' Tale: Professionalism and Public Trust* (Abingdon: Radcliffe Medical Press, 2003), 121-35, 161-72.

⁹⁰ Irvine, *Doctors' Tale*, 139-59; 183-84; Roz Sullivan, 'All Changed: Changed Utterly – The Disciplinary Process of the GMC, 1858-2012', *The Scottish Society of the History of Medicine, Report of Proceedings*, Session 2012-2013 and 2013-2014 [publ. 2016], 4-8.

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